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**GROWTH OF SMALL, RESIDENTIAL LIVING PRO-
GRAMS FOR THE MENTALLY RETARDED AND
DEVELOPMENTALLY DISABLED**

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Growth of Small, Residential Living...

HEARING

BEFORE THE

**SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES, AND TECHNOLOGY**

OF THE

**COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES**

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

WASHINGTON, DC., MARCH 29, 1993

Printed for the use of the Committee on Small Business

Serial No. 103-8



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GROWTH OF SMALL, RESIDENTIAL LIVING PROGRAMS FOR THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED

MONDAY, MARCH 29, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES, AND TECHNOLOGY,
COMMITTEE ON SMALL BUSINESS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:16 a.m., in room 2359-A, Rayburn House Office Building, Hon. Ron Wyden (chairman of the subcommittee) presiding.

Chairman WYDEN. The subcommittee will come to order.

Today, the subcommittee continues its examination of new and emerging health care services dominated by the small business sector. The question before us at today's hearing is whether Government regulation of small group homes for the mentally retarded and the developmentally disabled—a \$11-billion-per-year business which has developed largely within just the last decade—protects clients against dangerous or abusive treatment and protects the taxpayer against fraudulent or wasteful spending of billions in public reimbursement dollars.

This subcommittee has found substantial evidence that patients and taxpayers are frequently being exploited by small businesses that run homes for the mentally retarded and the developmentally disabled. While most providers appear to be contentious and professional guardians of some of the Nation's most vulnerable citizens, many others may be doing a poor or even criminal job of preserving a very large public trust.

A key measure of our society is how it treats its less fortunate. For some of the 300,000 Americans who are living in 40,000 of these homes, many of them for-profit facilities receiving an enormous amount of public reimbursement, our society has failed its obligation.

The subcommittee has found evidence of individuals, who were retarded and severely disabled, being raped, beaten, and even killed in these facilities. Medicines were misadministered with sometimes disastrous results. The clients had their possessions stolen, and they were shut off from family and friends. State public officials charged with oversight had little or no knowledge of conditions within their homes or, at best, they only learned after very serious problems had occurred. The incidents detailed in the sub-

committee memo deaden the soul as well as chill the blood. Our country simply must do better.

The subcommittee found evidence that through complex financial organizations managers of so-called nonprofit homes can make enormous amounts of money by servicing shell facilities through overpriced sweetheart deals, and the stakes are very large financially. For example, in 1988, providers in this field secured \$4 billion from Medicaid, \$3.6 billion from title XIX under the Social Security Act, and an additional \$2.1 billion from Federal supplemental security insurance.

In State after State, small providers, operating hundreds of homes and programs in geographically dispersed locations, have successfully evaded quality assurance oversight. The system that is supposed to protect the developmentally disabled is swamped. Case workers responsible for oversight of these programs are critically overburdened. Some may have over 100 cases each.

Too often, providers are left to operate on a sort of "honor" system. State authorities believe that conditions are up to standard primarily because they have been informed that is the case by the care-giving company.

With respect to staff at the facilities, the subcommittee found a pattern of inadequate pay and undertraining. One academic expert, who has examined the impact of staff pay and benefits at these facilities, noted that providers too often pay wages competitive with the fast-food sector. As a result, the consistency of care and training is very much left to question. The pay and benefits problem mirrors a similar issue revealed last year in the subcommittee's investigation of quality of care in rehabilitation of the traumatically brain-injured.

There appear to be conflicting and confusing jurisdictional problems between Federal and State authorities. The provider community includes several multi-State companies, each featuring scores of facilities. Under Federal policy, the individual States have most of the responsibility for tracking the financial dealings of the large providers, an audit job that is simply beyond the ability of most State programs.

It is clear to the chair of this subcommittee that Federal oversight and accountability over these homes must be strengthened. At present, once a State obtains Federal Medicaid dollars to provide care for the retarded and the developmentally disabled, the job of assuring quality, the adequacy of auditing standards, and the screening of home operators is then left to State regulators whose performance is spotty at best.

The witnesses today will testify, and the chair agrees, that there are many good providers in this field. Government has encouraged their development as an antidote to the poor conditions and oppressive quality of too many large State hospitals, but the witnesses will also add that the wide open regulatory nature of the environment, coupled with a steady flow of poorly monitored public spending, has created substandard and even dangerous care for too many of the patients.

In the last decade, thousands of developmentally disabled citizens have left the large institutions for the small, which promise to house, train, and employ them. The chair believes, however, that in

too many cases the worst abuses of the large institutions are being recreated in the miniature. There is a great need for improved State advocacy programs. Today, advocates can only address the most egregious abuses while far more stealthy providers, doing only the bare minimum necessary to meet State paperwork requirements, get by, and clients languish amid depredation and neglect.

It is possible to have enhanced standards of care for the vulnerable while still keeping the regulatory gate open for the development of innovative programs and good quality, new providers. Indeed, in many States a principal problem is that there is no competition, and there are too few providers. The subcommittee has been told, for example, that States may be stuck with a poor operator simply because there is no other provider ready, willing, and able to step into the breach.

We are going to hear from a number of experts from around the country discussing various problems. Al Medonis of the Massachusetts Auditor's Office will tell how his State may have lost as much as \$50 million in the last 4 years to dubious business persons who set up shell corporations to build and operate small group homes and use questionable lease-backs and profiteering at the expense of their clients.

Other witnesses, family members, and a former employee of a group home will tell even more disturbing tales of clients raped in homes operated for years under the nose of State authorities. We will hear of home operators who failed to notify guardians when clients wander off and have kept abusive employees on the payroll long after problems arose. We will also hear descriptions of underpaid and undertrained employees and of States that prop up poor providers because they have nowhere else to place clients.

As we look to the future of health care reform in this country, and particularly the long-term needs of the developmentally disabled, it is critical that we have better quality assurance programs. States must develop an approved system of quality assurance that meets standards sufficient to protect the vulnerable. The Federal Government should work with the States so that each State has a quality assurance program designed and in place to qualify for a Medicaid waiver.

In addition, it would be in the public interest to establish a national information exchange on quality assurance and enhancement efforts. States and providers need quick and reliable access to programs that work. States also need to know quickly about the track record of providers and their personnel in order to weed out the incompetent and the crooks.

Finally, States must establish minimal training requirements for facility employees. Again, authorities need flexibility in designing training programs, but, given the fact that the subcommittee found in State after State abusive treatment that can be traced to poorly trained and managed staff, training must be improved.

The subcommittee would discourage States from overreliance on any single provider and encourage them to beef up financial auditing of providers. Abusive providers, providers with a history of violations, need to be run out of business quickly.

Finally, there needs to be improved efforts by States to know where the money goes and how it is spent. Only in this fashion can we assure that the millions now lining the pockets of bad operators will be used for enhancing the lives of the mentally retarded and developmentally disabled.

The chair wants to thank our witnesses, many of whom have been working with the subcommittee and our investigators for more than a year. The subcommittee tried to get a representative cross section of views from States and programs across this country. We thank the witnesses for their patience.

[Chairman Wyden's statement may be found in the appendix.]

Chairman WYDEN. Before we hear the testimony of our witnesses, I want to recognize my friend, the gentleman from Arkansas, who has been a very helpful member to our subcommittee in the early days of our activities. I recognize Mr. Dickey for any opening statement that he would care to make.

Mr. DICKEY. Mr. Chairman, I thought the statement was excellent. I appreciate the statement.

Chairman WYDEN. I thank my friend and look forward to his participation. As he and I have discussed, this subcommittee goes about its work in a bipartisan fashion, and there is certainly nothing partisan about these issues. We thank the gentleman and the staff of the minority for their cooperation.

Chairman WYDEN. Let us turn now to our first panel of witnesses: Ms. Marlene Carson of Aloha, Oregon; Ms. Anita Ellis of Milwaukee, Oregon; Mrs. Gerald Oakes of Almont, Michigan; and Mr. Al Medonis, regional administrator, director of special audits, of Boston, Massachusetts.

It is the practice of this subcommittee to swear all the witnesses who come before us. Do any of you have any objection to being sworn as a witness?

If you would, please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. We are going to make your prepared remarks a part of the hearing record in their entirety. Please take 5 minutes or so to summarize your principal concerns. That would be very helpful.

Mrs. Carson, why don't we start with you. Again, we welcome you, know of your long trek to Washington, and appreciate your commitment and advocacy.

TESTIMONY OF MARLENE CARSON, VICE PRESIDENT, PARENT SUPPORT ORGANIZATION FOR THE DEVELOPMENTALLY DISABLED

Mrs. CARSON. My name is Marlene Carson. I reside in Aloha, Oregon. I have been asked to testify before you today by Congressman Ron Wyden. I am a parent, family advocate, and vice president of a parent support organization for the developmentally disabled.

My son, Douglas Eichler, was born on this day, March 29, 34 years ago. He appeared to be a normal active child until he was about 4 years old when his development fell behind other children his age. The mental retardation diagnosis stems from medication

given to me by my physician during pregnancy for extreme nausea. Doug was enrolled in a special education class in the second grade and lived at home until age 15, when he was committed to the Fairview State Training Center in Salem, Oregon, due to truancy and runaway problems.

Since Doug's entry into his fourth providership, I have kept a specific diary of all events, including names, dates, times, and places.

When Fairview Training Center began downsizing, the State Mental Health Division promised us his life would be as good as or better than at Fairview. After being transferred to a community setting three times in his 15 years at Fairview, in 1990 he was placed in the community again. This was a time of most difficult adjustment. During this period he ran away many times. His problems mounted; his possessions disappeared; food disappeared from his refrigerator as he complained to me that staff was stealing his food; he lost weight, developed paranoia, which precipitated rounds of medication which had not been previously administered; he became combative, depressed, and despondent about his living conditions.

The worst mistake I made as a mother and a guardian was not listening to my son as he expressed his fears to me on numerous occasions. The staff and the provider convinced me that Doug's perceptions were inaccurate and unfounded. I have apologized to Doug many times but feel he does not forgive me. He relied upon me to help, and I failed him.

I was told that staff was well trained and ready to meet Doug's needs when he was released from Fairview, but, in reality, their ineptitude to deal with the problems they assured me they had expertise with had overwhelmed them. I have been asked if the providership was adequately staffed, and the answer is an unqualified no. Staff were often not present in mandatory numbers, were double shifted, and in one staff-to-client altercation the excuse was given that the staff had been on duty 72 hours straight.

My son was permitted to prowl throughout the night in an area in which he resided, and as a result he was targeted as being suspect in suspicious activities by the police. This created a very dangerous atmosphere for him and the community. He was on new medications and, because he was not watched properly in very hot weather, suffered a seizure and ended up in a hospital emergency ward.

With regards to jobs for Doug and other clients, in order to provide gainful employment, the vocational agency, being paid large sums of money by the State of Oregon on a contractual basis, accompanied the client to coffee and doughnut houses and a shopping center. The vocational program was a weak link in my son's life. In my opinion, the trainer's skills were inadequate to deal with the problems which emerged. The program was a large expenditure of dollars with little or no results or accountability.

State oversights of program providers were frequent, but they did not resolve the problems that arose time and time again. There was little feedback when questions were asked; phone calls were not returned. When I expressed a concern or interest in the life or care not only of my own son but of those who lived with him, and

whom I have known for a long time, it was made abundantly clear to me that it was none of my business.

I have repeatedly asked for financial statements at the same time so that I could see where the dollars were going and to assist my son to understand the financial aspects of his life. I have asked for receipts of major expenditures, and, after many months of requesting this data, I received a printout of one month's summary expenditures, which I was never able to substantiate, as receipts for expenditures were not provided. The month was written in by hand in front of the year on the statement, and that document appeared to contain only approximate expenditures at best.

When we asked the assistant administrator of the Oregon Mental Health Division where Doug's money went, we were told that this information resided with the service provider. When the service provider was asked for the information, they said that all that information had been remitted to the State Mental Health Division and that should be a source of our inquiry.

To this day, we have received no reply to detailed reconciliation of Federal SSI revenues, the use of food stamps for clients, and other supported expenditures. These requests include the most recent one sent by certified mail.

Most clients in MRDD providerships do not have anyone to help them on an ongoing and permanent basis. Caseworkers change as often as four times a year, staff changes monthly, and, often, guardians or parents fail to make meaningful contributions. Clients need a constant and consistent person in their lives. They need someone not on the payroll, someone not representing the State or service provider. They need a person they know and trust and who is there for them in an advocacy role when needed. These relationships should be encouraged, not discouraged or intimidated, and clients should not be punished for their healthy friendships with advocates.

The service provider often sees the advocate, the parent, and the family as the enemy. This has to change, and it can only change when the provider attitude changes. The client is disenfranchised from the system and their own lives. They are subject to intimidation, harassment, and feel powerless to do anything for themselves; they just plain give up.

There are some providers who are exceptions and truly care about their clients, and this results in a very successful program. These providers, however, appear to be in the minority. Some providers say, "We want you to be involved," but their every action discourages participation. Do not ask for details, do not communicate with other parents, and do not try to talk to other families. The service provider wants the parent or guardian to be totally uninvolved, and that leaves the provider unaccountable, and the client and family are isolated.

The national trend is to downsize State institutions. For many people, community living is a dream come true, but for others it is a nightmare. The way has been paved for agencies of all kinds with all degrees of competency to move into States and provide services for a handsome return on investment. The money tree is alive and growing, and abuses are compounding one upon another.

What are these abuses? They include sexual abuse, physical abuse, property theft, theft of cash, fraud, including forged medical records, forged checks, forged signatures, including that of an attending physician in a Medicare fraud. Many of these discoveries were made by lay people, including myself, untrained in the mental health field. While these abuses were taking place, records had been certified as accurate by professional State employees.

Some would say this is a small group of isolated cases that should not reflect upon the whole provider system, and I would point out to you that these examples are related to just three group homes of one provider in the State of Oregon. This provider has approximately 18 group homes in Oregon and also operates in several other States.

Literature on similar events in other States indicates that such cases are much more frequent than many would have you believe. Bad staff who do get fired move on to the next provider, and the system makes no attempt to network a method of checking resumes. Whistle blowers have been and are being punished for contacting authorities about these deplorable events.

I was informed by others who had been involved as advocates for the retarded for a much longer time that, if we were to become active advocates in these troubling issues, our health, our reputations, and our lives would be severely impacted. They warned my husband and me that we would be threatened with lawsuits by the provider's legal counsel, that provider and State of Oregon representatives would and could harm us economically, and that we would be threatened by staff of the provider. All of the above came true.

For example, I recently lost a paid advocacy position within the mental health field, for which I was told I was eminently qualified, following telephone calls to my employer by an administrator from the State of Oregon and a private service provider. As they viewed it, I was too involved in the advocacy concept and had too many conflicts of interest.

I will continue to be a strong advocate for the retarded, and I am committed not to turn my back to the problems created by these providers and their friends, representatives of the State of Oregon whose reason for existence is to see that services are provided in a prudent, honest, cost-effective manner. I sit before you angry, with specific documentation to support each and every thing I have stated. I continue to be an advocate for the retarded, and I am committed not to go away from problems created by the abhorrent behavior of some providers.

[Ms. Carson's statement, with attachments, may be found in the appendix.]

Chairman WYDEN. Ms. Carson, thank you for your testimony. It is very helpful. I appreciate your being here and being willing to speak out. I am going to have some questions for you in just a couple of minutes.

Ms. Ellis, we welcome you. We will make your prepared remarks a part of the record. Please take 5 minutes or so and just talk to us. That would be great.

TESTIMONY OF ANITA ELLIS, MENTAL HEALTH CARE PROVIDER

Ms. ELLIS. OK. Honorable chairman and committee members, my name is Anita Ellis. I am from the State of Oregon, and I have 14 years experience in the mental health field. I am a former employee of three different care providers for developmentally disabled adults and am also a former care provider for the aged in adult foster care.

I began my career in 1977 providing direct care in an intermediate care facility. My responsibilities were to follow all individual service plans for each resident. My experience there was positive. Parents and families were involved, and I believe most were satisfied with the level of care provided for their loved ones.

This provider managed one of the first group homes in the area. After approximately 2 years, I transferred to the group home setting where we maintained that same positive level and quality of care for each individual. I left this employment to join my husband at this time as a provider for adult foster care but remained in contact with my developmentally disabled friends and served as a community advocate.

In 1988, I found myself as a single parent with children to support, so I sought employment at an intermediate care facility and was hired. I was transferred to their group home programs, and I was soon promoted to assistant program manager for two of the group homes.

A lot of things had changed. There didn't seem to be as much family involvement; staff were not as client oriented; the level of training for this particular program was very good, but some of the incentives were gone, mainly pay incentives for the employees.

After a few months in this position, I transferred to their work activities center. The program manager for the center had recently resigned, and the program was in transition. There was no work for the clients. The center at that time was more or less a babysitting service, and I was extremely dissatisfied with the situation. They stuffed envelopes and unstuffed them all day long.

I applied for a group home position at that time as a manager, and I accepted the employment on October 9, 1989, sight unseen, and I was appalled at the operational climate of the organization when I first walked into this home. The group home had been operating since January 1989 without a license or certification. There was no habitation, no training, and no transportation. The clients in the home were terribly mismatched; you had some very high-functioning individuals and very, very low-functioning individuals.

It had been said that this placement was due to an oversight by the development team when the program was originally planned. One person, a wheelchair-bound and nonverbal resident, paid the price of one of these oversights by the loss of an eye. The resident's roommate was extremely violent and extremely destructive. He destroyed thousands of dollars' worth of furniture and used a broomstick to poke the wheelchair-bound resident's eye out.

Many serious incidents have occurred in that particular program. These incidents included theft of a computer device being used for that wheelchair-bound resident who lost his eye, and this was his primary means of communication. Other incidents included

forgery of physicians' signatures, medication errors, missing documentation, client abuse, and negligence.

I was told to file a report with the insurance company that denied the claim due to an error made by the provider in completing information forms at the time of the enrollment for the insurance. I approached the provider to seek replacement for the device for the resident, and the provider told me to go back to the case manager and seek replacement through the client's trust fund. The case manager sent me back to my provider and said, "It's your responsibility." During the time that I was employed with this agency, during the 2 years, it was never replaced.

I was told by a reliable source that the new provider was brought in by the State of Oregon Mental Health Division. When the new provider arrived, they made grandiose promises to the staff as far as benefits, program improvements, but come February 1, 1990, when they did take over the program, it wasn't there; it didn't happen; staff were going to walk. We met, we talked, and there was a compromise, and so business went on. We did accept the compromise.

Initially, the new provider furnished some much needed staff training. There were plans for cosmetic changes and improvements, including new furniture and equipment. For the first time in the history of this program, there were individual service plans for each resident, and staff followed through with these care plans. This program was licensed and certified for the first time after 1½ years of operation.

I was promoted to program manager and asked to be involved in the development of new programs at that time. When we interviewed clients for possible placement in these new programs, I was told by my provider to be quiet, follow the lead of the development person. Most, if not all, of the residents interviewed were very medically involved and/or behaviorally involved. Some were arsonists, pedophiles, thieves, murderers. Many were placed in the two new facilities which resided in family settings with little regard to the individual's background.

Training was provided initially with the opening of each home, but the provider was reluctant to furnish any more training because of high staff attrition. There was an awful staff turnover, and a lot of time these people were placed directly into employment without any training whatsoever, and that was the only choice that we had.

With great difficulty, each of the new homes was eventually licensed and certified. When new staff were hired, it was the practice to check three references, take photocopies of identification, and have them complete employment application paperwork, including a criminal history check. The criminal history check form is sent to the Mental Health Division for handling. When the form is returned with its disposition, a determination is made whether or not the individual is employable. However, the practice was to place the individual into employment before the criminal history disposition was every determined.

It was and always will be difficult to maintain good staff. The pay scale is low, and there are no incentives; benefits are very weak; providers must compete with organizations such as fast-food

restaurants for employees. Potential employees often select this type of work rather than contend with some of the aggressive behaviors exhibited in some of the group homes.

When a serious incident occurs, or is alleged to have occurred, such as an abuse committed against a resident by a staff person, it is the responsibility of the provider to call Protective Services for an investigation. Staff are reluctant to complete incident reports for serious incidents as they fear retaliation from the provider and, in some cases, from the person allegedly committing the abuse.

In January 1991, a new executive director took over the program. When I reported alleged client abuses, the executive director was slow to react. I knew that these alleged abuses were serious and needed attention, and repeated attempts to stress the importance of the allegations were ignored. I went to Protective Services, as is required. The director became extremely angry with me for going over his head. As a manager, I was never provided the support that I needed, and I never received a budget to work from until September 1991, and I had worked for this agency since February 1990. Upon finally receiving a budget, I was informed that it was inaccurate and not to rely upon the data. This budget didn't even cover the entire fiscal period.

In July 1991, one of the group home locations became extremely infested with cockroaches, and the provider and the State of Oregon Mental Health Division were informed of the problem. In spite of repeated pleas to both parties for help, my staff and I received no response until some time in late October.

At this time, I summoned someone from the Mental Health Division to come and personally view the problem. This individual, after viewing the infestation, was appalled and approved diversion funds to assist the residents in staying in a motel while the residence was being fumigated and cleaned. It was at this time that the executive director came to visit this program for the first time in 10 months. He refused to even walk into the apartment.

After the apartments had been professionally fumigated and cleaned, the residents were forced to move back even though there were still live cockroaches. In good conscience, I could not make them stay in their infested apartments and arranged for them to camp out in my office and the other two group homes.

I was working around the clock, as were the other home managers. Finally, diversion moneys were allotted for a group home site and the purchase of new furniture and supplies. We were told we could not take any fabrics or surface items, appliances, or papers from the infested site to the new site. We had to place all of these items in storage to be fumigated and donation to others in need.

At the new site, it was our problem to not only do all the moving ourselves but that we must also purchase all the new furniture and supplies. Once again, we worked around the clock with no assistance from the agency or the Mental Health Division.

The move was finally completed in December 1991, and I proceeded to work on client programs. I had just assumed responsibility of my former group home along with my program manager's position. An on-site inspection was scheduled, and we were warned that the inspection was going to take place for December. It is a matter of record that during my time as program manager for the

home we received top scores during this on-site inspection. I maintained this high rating for all homes under me.

Previously, under another program manager, the group home had seven different home managers in approximately 1 year's time, and, to my great distress, during my tenure I was not able to correct all the problems in this program. The program was not fully staffed or adequately trained, and the program failed on-site inspection miserably.

When the on-site team interviewed staff individually, we were informed that our conversations would be held in strict confidence, yet some of the things that were stated in confidence were communicated to the executive director, and this was revealed in this person's anger toward me and my other staff.

Please remember that I was still program manager for two other group homes during all this pandemonium. These were still problems in a newly sited program. There was no food. The home manager was not available. I purchased food with my own money. I telephoned the home manager and left messages but was unable to contact him. Finally, after Christmas, I was able to make contact with this home manager to get residents' finance logs. Upon viewing these finance logs, I found that there were missing pages; bank statements were missing and had to be ordered from the bank; and receipts did not match expenditure records. I reported these inaccuracies to the executive director, and he ordered me to perform a client audit.

I completed one audit—once again, an around-the-clock ordeal—and found that there was a possibility that client funds had been misused. The executive director immediately suspended me without pay on January 9, 1992, and handed the finance logs and checkbooks to the individual whom I had implicated. This individual continued to mishandle client funds and actually forged my signature on checks.

I called the Oregon Mental Health Division and reported this activity. They did nothing. I requested meetings with the provider to try to resolve the situation, but they refused. Many staff were angered and wrote letters on my behalf. Staff also telephoned me at home following my suspension to tell me that my files and records were being removed from my office and fed into a paper shredder. The home manager I had implicated was eventually discharged. Eventually, I received a letter from the provider explaining that my suspension had been elevated to termination. I was never given the dignity or courtesy of a meeting to discuss the reasons for my termination.

I have steadfastly applied for every job opening in the mental health field that I could find. This resulted in one interview. I have observed personnel managers, whom I have never met, who, upon reading my name at the top of the application form, shake their heads and return the application to the receptionist. I have good reason to believe that I have been blackballed in both the private and public sector on this industry, a field for which I have extensive training and experience.

Many of the residents I served have been denied access to me by the provider and by the Oregon State Mental Health Division. Many staff who have worked with me and who have offered me

support have been harassed, demoted, or forced to leave employment with this agency. These actions took place following the onset of an investigation and airing of a five-part series on this agency by the local affiliate of a national television network. The agency's attorney and new executive director approached some of these staff personnel and asked them to sign an affidavit falsely accusing me of improprieties, and in one such case the individual who was under investigation for client abuse for the fourth time received 5 weeks severance pay and a letter of recommendation in exchange for a deposition falsely accusing me of these improprieties.

I am not here to appear to bash my former employer, and I remain hopeful that this situation will change, and that I can return to the field in which I am highly trained and qualified. I am here to advocate for these people who I have served for the past 14 years, and I want to see something changed. Something has got to be there to help these individuals, There has to be some quality assurance, and we want you to help us.

Thank you.

[Ms. Ellis' statement may be found in the appendix.]

Chairman WYDEN. Ms. Ellis, thank you very much for a very helpful statement. Your willingness to speak out gives us the information we need to prevent these problems from occurring at home and across the country. I will have some questions for you in just a moment.

Mrs. Oakes, welcome.

TESTIMONY OF JOAN B. OAKES, HOMEMAKER AND ARTIST, AND GERALD C. OAKES, PROFESSIONAL ENGINEER AND VILLAGE MANAGER

Mrs. OAKES. I would like to submit the following as testimony regarding our experience with the Michigan mental health care system as related to the sexual abuse of our retarded daughter for 4 years by an adult foster care facility operator and owner.

For the record, we are Gerald Oakes, professional engineer and village manager, and I am Joan B. Oakes, homemaker and artist. Our residence is 439 McIntosh in Almont in the State of Michigan, county of Lapeer. We have four children. The youngest is Maureen, 31, who is mentally retarded, subject to seizures. Her overall mental age is 12.7 years. Maureen lived at home until she was 16 and attended public schools in Detroit, one private day care program in Grosse Pointe, and Wayne County Intermediate School Program.

At 16, the behavior problem became so great, we had to place her, and we chose a private, Catholic, residential boarding home, Our Lady of Providence, operated by the Sisters of Providence out in Northville, Michigan. She remained in this setting for 6 years, when it was encouraged that we find other placement, again, because of behavior problems.

So, we went to St. Clair County Department of Social Services, where she was placed in a small, adult, foster care home. She lived there approximately 9 months. When her behavior became a problem, she was moved to a second home in Marysville, also in St. Clair County. She stayed 9 months. Her problems grew so bad, the

violent acting out, tantrums, that we were asked to take her out. She stayed with us until early 1987, and we contacted Lapeer County Mental Health Agency, where we were now living, in Lapeer. They helped us place Maureen in His Majesty's Christian Center in Otter Lake. Since she has been removed from Otter Lake, His Majesty's, she has been in two more adult foster care homes. Her behavior continues to be a problem as a result of violent thrashing out against the people around her due to frustrations, and so on, and so forth.

We have sought specialists in medical treatment to help us with the behavior problem. Right now, she is on Depakote to control seizures and Benadryl for sleeping, with which she has a problem occasionally. Prior to this, she was on a huge amount of Dilantin—I mean Phenobarb and a small amount of Dilantin, Mellaril, Halcion, and Ovacon, which was required in St. Clair County; she had to have some form of birth control. She has since been removed from that.

The Otter Lake facility was only open about a year when Maureen entered. The staff seemed very caring. The name, in itself—His Majesty's Christian Center—was reassuring to us. We were very trusting, relying on the owners, Dave and Marion DeLauter, who seemed trustworthy, understanding of our problem. We have no detailed knowledge of the types of licenses held at His Majesty's Christian Center at the time. We trusted the community mental health workers to know that the requirements were being met.

At the time Maureen was placed at His Majesty's, we were suffering emotional burnout due to the many years of dealing with the violent behavior of our daughter. We were not aware of the rights of our daughter, rights under the mental health care system; we were not told our rights.

This facility, His Majesty's Christian Center, was originally the old American Legion Home for Boys. It had two large dormitory type buildings, a modern, single-level senior citizen building, gymnasium, and two small homes, and a maintenance building. The building Maureen was in was housing for young adult retarded. Males were housed on the second floor, and seven females on the first floor.

During the 4 years Maureen was a resident, the DeLauters expanded the utilization of other buildings on the compound. At one time, Community Mental Health leased the large building known as the gym for their day care program while their new building was being completed. Some of their staff was housed there, too.

We were only mildly aware of the drug abuse program maybe about 6 months before Maureen left. We were aware there were more people there, but we were really not aware of what their problems were. It probably was Christmas, before the sex abuse was brought to our attention, that we were aware of the large number of people in this drug rehabilitation program, and it was unlicensed, but we didn't know this until after. We were unaware that felons were being housed at the place.

We were never really aware of anything that we could classify as improprieties until the sex abuse came out on February 24, 1991. We might not have been impressed with all of the workers we encountered there, but there was quite a rapid change-over. The De-

Lauters, we trusted them to protect our daughter. They lived on the site, so we figured all was well. They had the church of their own. Maureen was even baptized at the center, and it gave us a general feeling of security for her.

We had tried to break contact with Maureen to some extent to help break her dependency on us. Overall, she really never complained, seemed basically happy out there. Her behavior seemed to improve to some extent; at least, that is what we were led to believe. Our visits were going well with her.

To describe how we were first notified about the abuse, I would like to start with the day before, Saturday, February 23. We had made arrangements to pick Maureen up for an afternoon of shopping and taking her out to eat, and this went exceptionally well for us. The following day, I received a phone call from Marion DeLauter asking us how our outing had gone the day before, and I said very well. She said, "You had better sit down because of what I have to tell you." I told her I was sitting, and she began with, "Your daughter and four or five other female residents are accusing Dave of sexually abusing them." My reply was, "Oh, my God," and made reference as to how upset she must be, and I cannot recall what else I said, but I realized I just couldn't think clear, and I had to talk to my husband after this and asked if I could call her back.

Once I spoke to Jerry, it was decided that we should go out and speak with Maureen and ask to find out what's going on, which is a 45-minute drive from our house. We said very little, and I'm sure both were thinking at the same time, "This has got to be a mistake; this can't be true," and yet we knew something had happened.

Marion and Dave, when I had called them and told them we were on the way out, had said please stop by their house before going to talk to Maureen. Both Marion and Dave spoke with us, mostly Marion. They explained that the accusation was made on Saturday evening. Staff did not follow their procedure, which was to call them first or manager Sue Sanford in a case of emergency. The staff did call another staff person, who then called the Lapeer County Sheriff, which is correct procedure under the law.

The Sheriff's Division came out and began questioning the females and decided it would be best to have a female deputy do most of the questioning, and that went on most of the night.

We found out there were a total of four other females at the time in this original questioning. We asked Marion DeLauter if we could have the phone numbers of the other parents since they had already picked up their daughters.

Marion and Dave claimed the girls were together in one of their bedrooms on Saturday night making up this whole story. Marion said three of the girls used the same story word for word. She mentioned three because one female was home for the weekend and could not have been in on the plot. Dave mentioned that they said only fondling and oral sex but no intercourse was involved.

Now Dave had given us the key to his private office so that we might question our daughter in the privacy. We found out later that his office intercom had been open to his home so that he could monitor our conversation.

Maureen was sleeping when we got into the building to pick her up on the way over to Mr. DeLauter's office. She had been up all night. She said they had gotten to bed about 4 o'clock in the morning after all that questioning.

When we took her into the office, we found that it locked with two locks. Once we were inside the office, we asked Maureen what had happened. She was very uncomfortable and reluctant to talk. She said one of the girls had talked to staff on Friday night and that the police talked to her on Saturday night. We asked her what she had told police. Maureen said that she told the police Dave had her come to this office and do relaxing exercises with her. She said he touched her "boobs," which is her words, and he touched her there, pointing to her crotch. She said sometimes the other girls were in the room also. I asked if he locked the door, and she said yes. I asked if she felt uncomfortable and she said she wanted to come home.

We packed a few things, took Maureen to our car, and went back to DeLauters' home to return the key. At this point, Marion said that they could not go to the Bennett Building, where the girls were living, which Dave said no one could stop him from seeing his girls—a very arrogant man, which we found out.

We did receive the phone numbers from all of the other parents involved. We were not sure of all the details, but we definitely were sure that something had happened; there was sexual abuse involved. We kept Maureen home for the day, and the following day I called them and said Maureen would stay with us for a while until things got straightened around.

February 28th, we were asked to bring Maureen down to the State Police Post in Lapeer for questioning. We asked to be in the room with her, but that was refused, though there was an Adult Protective Services representative with the officers, so we did feel better. Our fear was that because Maureen was retarded and did not understand what happened to her she would not respond to the questions as a normal sex victim would.

Later on, she went through more questioning, the Attorney General's Office, the Department of Social Services Licensing. I believe they said there were six questionings in all, and I will briefly try to give you those dates. Originally, by staff on the night, Saturday night, February 23, 1991; the first sheriff deputies questioned them the same night and called in a female sheriff deputy, and this questioning continued until 3 or 4 o'clock in the morning. The following Tuesday, the State Police, Adult Protective Services representative at Lapeer Post; the females were questioned one at a time; Michigan Department of Licensing investigators came to our home to question our daughter, the 14th of March. March 20th, we were requested to bring Maureen to the Department of Social Services office in Lapeer to have a complete evaluation with a therapist, Tom Seibert. At that time, pubic hairs were also taken for lab tests.

April 30th, the Attorney General's Office requested we bring our daughters to the State Police Post for questioning. The Adult Protective Service representative was also there for the support of the girls during this questioning. The court times that the girls had to appear were the pretrial, August 12, 1991, and the actual trial

which started in the first of October and ended on the 11th of October, but each of the females only had to appear one day.

Then there was the licensing hearing. They were requesting that each of the females be brought in to testify, and these dates kept changing, many inconveniences for all involved. We tried to stop having our daughter and four of the other females from testifying again, because they still had the trial to go through.

Our attorney tried to stop it by filing a motion and went to a Lapeer court with this, and the judge said he understood, he thoroughly agreed with her, but he didn't want to interfere; this was a political hot potato. So, we did go the date required for our daughter to come in for testifying, which was July 23.

I went, and my husband, our attorney, another mother, and the attorney brought the depositions from the other parents, explaining why we felt it was unnecessary for these females to have to testify again when the DeLauters' attorney had finally resigned due to lack of money, and a board member, close friends of DeLauters, was doing the questioning as well as Marion DeLauter. We felt these two people could definitely intimidate the females, and it wasn't really necessary for them to be put through this again. They agreed to delay it until after the trial.

Now, during all this time, no one through Community Mental Health, State, anywhere, suggested we take the females in for a complete medical exam after all this. We each did it on our own. Our Community Mental Health had no specialized counseling to offer our daughter after this sex abuse. We sought private counseling.

We were kept in the dark pretty much about this whole investigation. It was through Detroit news investigative reporters, people we called who were kind enough to give us some information through some of the agencies, but nothing official; we heard many rumors.

We were aware that many different Government agencies were investigating this case—Federal Labor Department, Welfare Fraud, Medicaid Fraud—and still, we have heard nothing as to what they really came up with or whether they have taken any steps to do anything about it.

We did hear through rumors that, due to the closed workshop that Mr. DeLauter and two other people, his partners, owned, that many of the drug abuse residents were working under slave labor conditions, and they owe approximately \$70,000 in back pay.

Staff who were hired by DeLauters were told to report any emergencies to them first, and they feared for their job doing otherwise overall. It was just a few who finally took the steps to bring it to the attention of the police of their suspicion of the sex abuse. Mr. DeLauter also used rather abusive physical force with some of the drug rehab males if they didn't want to get up and go to work. He slammed one of the young men up against the wall, who was recovering from back surgery, approximately 2 weeks out of the hospital.

The workshop apparently didn't always have a lot of work, but when they did they were encouraging the residents, all of them, licensed and unlicensed, to work long hours.

Our daughter did tell me she didn't want to work long hours, and that Mr. DeLauter did allow her not to, but I am sure, because I know, she told me several times, she did agree to go into work in the evening because they needed extra help, so he charmed her into it. This is what he did with some of the females—charmed them into it, getting them to cooperate in other ways. He threatened the mentally ill with being admitted to the hospital again.

Two Community Mental Health workers were charged and found guilty of failing to report sex abuse reports by two clients at His Majesty's earlier in the year. They claimed they did report it to their superiors and nothing was done about it. Superiors claimed they reported it to the next step and nothing was done about it, so it was a sing-song kind of thing.

The whole thing was an ordeal that I never want to have to ever go through again, but, being our daughter is in this predicament, she is very vulnerable. We are aware that there is a lot of it going on that doesn't even get reported.

We feared that the case wouldn't even go to trial because Government agencies investigating other Government agencies have a tendency not to like doing that. We feared it would be swept under the carpet, but, fortunately, we have had two attorney generals involved in the case, both females, and our attorney, who is a female, worked together and brought this to trial.

We had requested that they seek specialized groups that have experience with questioning, videotaping MI&DD, working with police authorities in the questioning. It could have helped avoid the six times of being questioning, but we were told by these agencies that the attorneys would have to request this service; we could not bring them in ourselves. There seemed to be a hesitance attitude toward bringing anybody in; it was sort of, "Don't tell us how to do our job," though I have learned that the attorney generals involved in the case are now contacting these various agencies in dealing with problems of this sort.

[Mr. and Mrs. Oakes' statement, with attachment, may be found in the appendix.]

Chairman WYDEN. Mrs. Oakes, thank you very much for your testimony. The account you have given us has been extremely helpful. I know these are difficult issues to talk about. One of the reasons we were so interested in having you come is that it is absolutely key to hear from parents like yourselves if we are going to keep this from happening again. I will have some questions in a moment. We sure admire your courage and willingness to speak out.

Mr. Medonis, welcome. We will make your prepared statements a part of the record. Please summarize your views in 5 minutes or so. That would be helpful.

TESTIMONY OF ALPHONSE V. MEDONIS, REGIONAL ADMINISTRATOR AND DIRECTOR OF SPECIAL AUDITS, ON BEHALF OF JOSEPH DeNUCCI, AUDITOR, COMMONWEALTH OF MASSACHUSETTS, ACCOMPANIED BY PAUL McLAUGHLIN, AUDIT SPECIALIST; RICHARD POWERS, SENIOR FORENSIC AUDITOR; AND PAUL STEWART, ASSISTANT FORENSIC AUDIT MANAGER

Mr. MEDONIS. OK. Thank you, Mr. Chairman and members of the committee. It is a pleasure and a privilege to appear before you this morning on behalf of State Auditor A. Joseph DeNucci, auditor of the Commonwealth of Massachusetts.

Before I begin, I would like to take this opportunity to introduce my colleagues: Mr. McLaughlin; Mr. Powers; and Mr. Stewart.

I have been asked to comment on our experience in the Commonwealth of Massachusetts with regard to illegal acts, waste, and abuse in the billings by vendors who provide services for the mentally retarded and developmentally disabled. The industry is generally honest. However, our experience has shown that providers are routinely reimbursed for items that are unreasonable and unallowable under the existing regulations.

In our opinion, illegal acts, waste, and abuse are not unique to Massachusetts nor to the provider community. Our office is conducting an investigative audit, in conjunction with the Justice Department, regarding a scheme to defraud which has expanded into five other States: New Hampshire; Rhode Island; Connecticut; New Jersey; Virginia; and the District of Columbia.

Chairman WYDEN. Mr. Medonis, let me interrupt you on that point. Are you saying that your office and the Justice Department are part of an investigation that is ongoing today?

Mr. MEDONIS. Yes; we are currently working with the U.S. Attorney's Office in Boston.

Chairman WYDEN. OK. Please proceed.

Mr. MEDONIS. At this time, rules of grand jury secrecy have prevented us from sharing our knowledge of these illegal alleged acts with the other States through our intergovernmental network. Additionally, your committee has asked for our views on improving the system. After reading our prepared remarks, we are ready to answer any questions from the committee members.

The Commonwealth of Massachusetts has been utilizing private contractors as an important part of its human service network for over 20 years. A substantial percentage of the services provided in this area are to mentally retarded and developmentally disabled individuals. During this period, the industry has grown from a small number of community-oriented service providers to a significant industry, including providers who operate in multiple States or serve clients from other States and foreign countries. The private providers serving these populations in Massachusetts are currently regulated by no fewer than five State agencies.

The explosive growth in this industry, spurred by deinstitutionalization, outstripped the Commonwealth's ability to effectively regulate the programmatic content and financial conduct of provider groups. The different priorities of purchasing and regulatory agencies resulted in duplicate and, in some cases, contradictory regulations.

By the late 1980's, the system had reached a point of virtual gridlock. Regulatory agencies were no longer able to coordinate the licensing, rate approval, program development, and oversight procedures in a timely or useful manner. In an attempt to break this logjam, a new rate approval process was established. As in previous attempts these changes failed to develop a stable, responsive, and cost-effective network of providers.

During the past several years, Auditor DeNucci's office has completed a series of audits which have demonstrated the weaknesses inherent in the current system. These systemic blind spots have allowed certain providers to engage in illegal activities and to divert funds to inappropriate uses. In three cases alone, we have identified and the Commonwealth of Massachusetts is attempting to recover over \$7 million. We believe that stronger reporting requirements, review techniques, development of specialized audit plans, and a combination of selected and random audits would lead to the identification, detection, and recovery of \$50 million of State and Federal funds.

The absolute reliance of providers on the rate combined with the absolute need for the services provided by them has created a situation where each party holds the other hostage. This is not only unhealthy, it is expensive. Providers protect their rate structure by exhausting income on reimbursable costs. Therefore, when an unexpected expense or fluctuation in enrollment occurs they are forced to seek a rate adjustment. Conversely, when a program encounters financial difficulty, the purchaser needs to protect their clients. This is normally accomplished by increasing the financial commitment to the provider.

Since rates are generally approved on a unit or enrollment calculation, providers must operate at or near capacity to break even. The practice of expending resources to maintain rate integrity leaves few providers with resources available to expand operations to meet a new demand for services.

The existing methodologies do not lend themselves to timely rate processing and program approval. This prevents the purchaser from using new programs as placement options. These system weaknesses make it easier to increase funding to a struggling program rather than find a long-term, effective solution. We also believe a more effective regulatory process and a redefinition of the provider's role could result in an additional \$60 million in savings in the State of Massachusetts.

We feel confident in these projections for two reasons. First, the reimbursement system in the Commonwealth has never truly promoted effectiveness but has given tacit approval to wasteful procedures through regulations that use program expenditures to justify costs as opposed to measuring program effectiveness in determining value.

Oftentimes, improper allocation of direct costs, schemes that lead to personal enrichment, and excessive executive salaries and benefits are included in the final rate of reimbursement. A 2.5-percent increase in effectiveness in the Commonwealth's estimated \$2 billion in human service expenditures could result in \$50 million in savings.

Second, the elimination of accountability controls and external audit presence has created a safe haven for those who choose to abuse the system. The failure to disclose related party activity in real estate transactions and many other activities simply are not picked up in the course of a so-called desk audit. The results of our field audits indicate that certain basic strategies are employed on a recurring basis to drain funds from the system. These strategies result in excessive costs being passed to the Commonwealth for the following type of undisclosed related party transactions: First, real estate transactions where the provider is both the lessee and the owner; second; shell companies, set up to procure goods and services, add an artificial layer of costs and deliver them to the provider; and, third, for-profit management companies to manage the nonprofit providers.

Fraud, waste, and abuse is not unique to Massachusetts nor to the provider community. The health care system nationwide is easy to defraud because the payer is not always a buyer or seller of the services. Therefore, payers don't always know if they are getting value for their dollar.

Within the Commonwealth, the human services industry is one of the most heavily regulated industries. We believe that accounting principles and auditing standards are adequate enough to ensure proper accounting and reporting. We view the major problem as the failure to comply with existing requirements. It is in the monitoring and enforcement of these regulations that we see the greatest potential for improvement and the reduction of illegal acts, waste, and abuse. Streamlined but meaningful cost reporting combined with enforcement tools and external audits will promote compliance and a resultant cost savings.

The Commonwealth has enacted a new debarment statute sponsored by State Auditor DeNucci which allows for the suspension or revocation of contracting privileges. This process places at the Commonwealth's disposal a tool with which to promote compliance. We have for your convenience enclosed a copy of the Debarment legislation in your briefing package.

Auditor DeNucci has also proposed legislation which clarifies the definition of and the disclosure responsibilities of related parties. This legislation, when enacted, will close another gap in the existing system.

What remains is the development of industry models, simplification of the existing cost reporting system, the development of specialized audit plans and procedures, and a consistent external audit presence. The most effective tool in the protection of Federal and State resources is in the audit. This process allows Government to determine that funds expended were, in fact, used for purposes intended.

Unfortunately, the general procedure is for these agencies to conduct only desk audits. In Massachusetts, only the Auditor of the Commonwealth conducts external, independent, and objective audits. Desk audits are minimally useful, lack independence, and promote a cumbersome, paper-intensive, cost-reporting, and rate-approval process. Reporting requirements, rather than the appropriate utilization of funds, becomes the focus of the system.

The cost-reporting and rate-review process should be separate from the audit process. The splitting of these functions allows each group to concentrate on those areas most important to them and with which they have the greatest level of competency. The system should be streamlined so that cost information can be submitted in a timely and meaningful format.

Trained and experienced auditors should review the financial operations of the providers and select vendors for audit based on the information contained in the cost submission. An additional group of providers should be selected at random for an audit of their operation. This accomplishes two equally important goals. First, it maximizes the ability to identify and intervene in potentially abusive or illegal activity, and, second, it allows for the development of industry statistics and norms for future measurement and analysis.

It is our belief that a combination of selected and random audits will do more to increase compliance than any change in regulation. Improved oversight, and the increased protection that it offers, is dependent upon a more timely and meaningful reporting system.

We, as Government auditors, are uniquely qualified to review, analyze, and synthesize financial statement information for this purpose. We understand the programs and their flaws and are able to design protocols, audit plans, and develop industry models that would enhance the ability of the Commonwealth and other States to effectively monitor the financial activity in organizations providing services to mentally retarded and developmentally disabled populations.

In closing, we advocate streamlining the cost reporting system, intensifying the audit process, and incorporating penalties such as debarment, to ensure compliance with existing regulatory standards combined with meaningful regulations that identify specific costs and activities that are unallowable, unreasonable, and, therefore, not reimbursable.

We thank you, Mr. Chairman. We would be happy to answer any questions.

[Mr. Medonis' statement, with attachments, may be found in the appendix.]

Chairman WYDEN. Mr. Medonis, thank you. I want to begin the questioning with you. I think that is a very powerful statement. You are an accountant working for the State?

Mr. MEDONIS. Yes; an accountant.

Chairman WYDEN. You have told us that the Justice Department and your office have an ongoing investigation into problems in five States?

Mr. MEDONIS. Exactly.

Chairman WYDEN. These are New England States?

Mr. MEDONIS. Virginia, New Jersey, and the District of Columbia.

Chairman WYDEN. OK.

I am especially interested in knowing whether the companies that you found engaging in illegal schemes in Massachusetts are operating homes and facilities in other States at present. Are they?

Mr. MEDONIS. They are.

Chairman WYDEN. Do you know how many other States they are operating in?

Mr. STEWART. I believe seven other States.

Chairman WYDEN. Do you anticipate your associates participating in the questioning? We have a formality here, and we must swear these nice gentlemen in.

Mr. MEDONIS. Yes; I wish you would.

Chairman WYDEN. All right. Gentlemen, please come forward. Please identify yourselves for the record.

Mr. STEWART. Paul Stewart, Mr. Chairman.

Mr. POWERS. Richard Powers.

Mr. McLAUGHLIN. Paul McLaughlin.

Chairman WYDEN. Are all three of you are with the Auditor's Office in the State of Massachusetts?

Mr. STEWART. Yes; we are.

Chairman WYDEN. Very good.

Do any of you have any objection to appearing here as a witness and being sworn in as a witness?

Please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. Let me just repeat that question for the record. You found companies and individuals involved in problems in the State of Massachusetts. How many other States were those companies and/or individuals operating in at present? I understood you to say about seven.

Mr. STEWART. In addition to Massachusetts, they operate in New Hampshire, Rhode Island, Connecticut, New Jersey, Virginia, and the District of Columbia.

Chairman WYDEN. Very good.

Now, I want to pin down these very substantial savings that you are talking about, Mr. Medonis. As I understand it, on page 2 of your testimony you talk about efforts that could save \$50 million of State and Federal funds. Then on page 3 you talk about how more effective efforts in the regulatory area could lead to an additional \$60 million in savings, thereby totaling up to \$110 million in savings in Massachusetts alone.

If you look nationwide, is it fair to say that the recommendations you make today could lead to freeing up billions of dollars that could be more effectively spent on caring for the mentally retarded and developmentally disabled?

Mr. McLAUGHLIN. Mr. Chairman, the numbers that we have given you represent the savings that we would view possible within the Commonwealth in human services. It is a bit larger population than just the mentally retarded and the developmentally disabled. Massachusetts is also a State that, over the years, has developed a very, very large network of providers. I am not sure that other States are as deeply involved in terms of gross dollars and gross number of people served.

Chairman WYDEN. Well, let me ask it this way. Of the \$110 million in savings, is it possible to pinpoint a more precise amount that could be saved just in the area of the mentally retarded and the developmentally disabled? Would perhaps two-thirds of this \$110 million be an appropriate figure? or half?

Mr. McLAUGHLIN. I would say under a broad umbrella, including those programs run by, for example, the Department of Education that would serve children who were mentally retarded or develop-

mentally disabled, I would expect that 50 percent of those savings would come from that area.

Chairman WYDEN. Are these annual savings or one-time savings?

Mr. McLAUGHLIN. The savings are broken into two types: Those we feel that are the result of waste, abuse, and fraud; they would be one-time savings; the savings as a result of effectiveness would be ongoing savings.

Chairman WYDEN. You believe that a substantial fraction of that annual \$60 million savings would apply to the mentally retarded and the developmentally disabled.

Mr. McLAUGHLIN. That is correct.

Chairman WYDEN. Well, these are very substantial sums, gentlemen. With this very large Federal deficit and the State being under great financial pressures—your suggestions are very helpful.

Mr. Medonis, I am interested in knowing the prevalence of shell company schemes. Please give a precise explanation of the way these shell companies do business. It is my understanding that this is a growing problem.

Mr. MEDONIS. We have included in our package over at the table there, Mr. Chairman, two recent audit reports that we issued regarding the indictment and conviction of three individuals who set up a scheme in the State of Massachusetts to defraud the State of Massachusetts in the amount of \$1 million. One of the principals last week was finally sentenced to—I believe it was 10 months for racketeering and made to pay back something like \$1 million.

The entire operation of these gentlemen was, they had furniture companies where they would go out and buy furniture, add a layer of costs, ship it off to another company, add another layer of costs. When it finally reached the State facility, it was maybe four times the original cost. The same way with your transportation of motor vehicles, your vans, they just set up phony companies.

Real estate companies whereby, if the individuals are supposedly related individuals, the reimbursement is only done on a cost basis. They would recover the cost of a group home within 4 or 5 years, they would charge such a heavy rent to the State. So it is quite a—

Chairman WYDEN. Let me ask you about this matter of Federal oversight, on which you make a number of very good points. I share your view that oversight and enforcement is the real challenge here. I don't see evidence that Congress needs to go out and write a crate full of new laws here. Instead, the challenge is beefing up Federal oversight. How can the Federal Government be a better partner in terms of helping States engage in enforcement action?

Our investigation disclosed that the central problem is that, after the Federal Government gives the State a waiver, usually a Medicaid waiver, the State provides quality assurance and auditing to trying to screen the providers, but the performance of the States often has been very poor. What can the Federal Government do to play a stronger oversight role and help people like yourselves on the front line?

Mr. STEWART. I think one thing, Mr. Chairman, would be to allow us to make it easier for the States to share information. I think the thing that you see that is becoming very fashionable to

do in the provider community is to set up shop in one State and then cross State lines and operate in other States, and individual States have a very difficult time chasing these providers, if you will, across State lines. So, I think it would be helpful if we were better able to share information with other States, and maybe that is a vehicle that the Federal Government could help us do.

Chairman WYDEN. Are there privacy restraints there. What is the problem? I sense a real pattern in what you are saying. There are a lot of problems with multi-State operations. Usually they are small businesses without many employees at any given site, and they are pretty mobile.

Given the fact that you have a Justice Department investigation into five States, and there are seven States in which you have identified problems, I would think that information sharing among enforcement officials like yourself would be critical. What is the problem? Are there privacy laws? Why isn't this being done today?

Mr. MEDONIS. Well, I think one of the problems is that when individual States do audits, they have no idea what the other State is paying for.

One of the things that we have started to do in Massachusetts in this first fraud that we were talking about—this came about as a result of questioning a \$20,000 purchase of furniture—as a result, we have had three people indicted, and we also gained knowledge of another attempt to defraud in these seven States.

We used the tool in working with the U.S. Attorney's Office of going in and seizing the records under an affidavit, which provides quite a tool for us, because it gives us all the records. A lot of times when you go in to do an audit, you don't get all the records; they hold back. So, this is one of the tools that we have used.

Chairman WYDEN. How can we make sure that information about a problem in one State gets transmitted to another State when somebody applies to run a home? I gather that you want information sharing to take place at the early stage of the licensing process rather than later after problems arise. Is that correct?

Mr. McLAUGHLIN. Correct.

There are essentially two separate processes: The licensing process and the financial process. Over the past 15 years, at least in the Northeast, those two have become combined, that the financial oversight bodies would depend on the licensing bodies to verify that the program is doing A, B, and C, that required more reimbursement.

Those agencies responsible for program supervision would then rely on the financial agencies to make sure that the money was being spent for those things, and they never quite matched.

I think one aspect that both of these types of agencies are missing is a central clearinghouse of information or standard to measure against. There are no financial standards that are just aimed at this industry. People have to go in and develop their own, and I think that it was just by accident that we happened to come up with 4, 5, or 6 people who understood the industry. I think, both on the financial side and on the programmatic side, there has to be standards that aren't inflexible but that people can measure individual programs against what that standard is.

Chairman WYDEN. That was very helpful. I want to recap all your suggestions for strengthened Federal oversight. The first is information sharing among the States to allow tracking of the problem carriers. The second is more uniform standards among the States in financial accounting and quality assurance.

Mr. McLAUGHLIN. Yes; but particularly in the development of a base line measuring tool. If you take program A and program B, one could cost \$20,000 and one could cost \$40,000. When you strip away the outside, the location, the cost of the real estate, and the cost of the vehicles, you essentially have two programs that should look very much alike. We would like to see something happen where we could measure the cost of that core program and then measure the add-ons.

In addition to that, we believe there are certain behaviors in these organizations that indicate something is going wrong. For a very, very simple example, when you see an agency—particularly a nonprofit—that has very few board of directors meetings or if that board of directors votes on virtually nothing, then you have a very, very strong indication that there could be a problem just beyond the surface.

Chairman WYDEN. This could be used as a signal by Federal and State officials across the country. If the States see a program that has very few board of directors, they must be aware.

Mr. McLAUGHLIN. Exactly.

Chairman WYDEN. Ms. Carson talked about the inability of parents to see budgets for the services provided to their children and expressed very understandable frustration and unhappiness about this situation. Does this happen frequently? Shouldn't it be possible? Shouldn't providers know how much is spent and where the money goes?

Mr. MEDONIS. Absolutely.

Chairman WYDEN. But presently, homes do not provide this information or homes are unwilling to divulge it in many instances.

Mr. MEDONIS. Exactly.

Chairman WYDEN. Is this a concern of parents across the country?

Mr. MEDONIS. It is a concern everywhere else.

Chairman WYDEN. It is a concern across the country, OK.

Let me ask you, Mr. and Mrs. Oakes, do you believe that the State of Michigan failed to monitor the records of His Majesty's for a lengthy period of time?

Mr. OAKES. I think in Michigan that responsibility has been transferred to the Community Mental Health, which is a county function under the county commissioners, although the State is involved with the Department of Social Services and the Department of Licensing, and, like was stated before, I think most of the oversight is self oversight. The Community Mental Health does come in and check on the conditions and to monitor the care, but it may be once or twice a month, something like that.

Chairman WYDEN. Would you say that between the State and the county authorities there was a failure to monitor the records of His Majesty's facility?

Mr. OAKES. Oh, definitely, yes.

Chairman WYDEN. When you initially brought up these kinds of problems did the staff know what the proper reporting procedures were?

Mr. OAKES. Well, they were instructed to report to the manager-owner, and on this particular night he was out of the site; he was on some social function somewhere else, and they couldn't reach him, so the staff contacted another staff person who had some authority, and she came in and immediately called the police.

Chairman WYDEN. Eventually the proper reporting procedures were followed, but it took some time to get their attention?

Mr. OAKES. I have every reason to believe that had he been on-site it would never have been discovered at all.

Chairman WYDEN. What do you think the State agencies need to do in Michigan to prevent such a recurrence?

Mr. OAKES. Well, what is happening in Michigan is, the State is moving away from monitoring and control over these programs, they are moving them toward the counties, and my personal opinion is that the State has to take over management, the total management function of these programs; take them out of the for-profit and the private owners. I have no faith at all that the private enterprise system will monitor itself or that the State can monitor.

One of the problems is that if something is discovered, as in this case here there were over 65 residents who were moved to other homes, so what you do is, you close down a home and then you have to place these residents somewhere else, and I'm not sure that the system that we have can address these concerns. I want closer monitoring; I want the State on the site.

Chairman WYDEN. I understand your exasperation with the lack of accountability. We are trying to figure out precisely how to address that.

Your daughter and the four other victims were questioned six times. Was that because there wasn't any coordination between the State agencies?

Mr. OAKES. Yes; definitely. We could never understand why the Licensing Department couldn't use the State's police investigation and why they had to have their own, although they were investigating some other things like shortage of supplies, food, and that sort of thing, but the crime itself—the reason that the license was pulled was because of the sex abuse, and that part of the investigation, they could have shared their knowledge.

Chairman WYDEN. I share your view that the State is going to have to be much more vigorous in its oversight of these facilities, particularly considering that many of these concerns are spawned by a change in State policy. We know that the initial State policy of deinstitutionalization spawned many of these concerns. I want to see the States take the lead in coordinating oversight in this area. As we do that, we must ensure that one State agency is talking with another. One listens to the kind of horrible situation you all went through, having somebody dragged through six separate inquiries just because there isn't any coordination between the State agencies, and one must believe that this is extremely unnecessary.

Mr. OAKES. Can I address that central clearinghouse that was mentioned by the gentleman from Massachusetts?

Chairman WYDEN. Yes, please.

Mr. OAKES. We were told by the State itself that if Mr. DeLauter was to apply in, say, the State of Ohio or Illinois, that he would be given a license because—if he was free, right, after 25 years? There is no background on these people from State to State.

Chairman WYDEN. We appreciate your coming. It is fine to talk about concerns and issues in the abstract, but it is quite another to hear the people who have gone through something like this. I want you to know we are doing this because we want to make sure that this kind of thing doesn't happen in the future. I appreciate your coming.

Ms. ELLIS, you worked in one of these facilities. I'm curious whether your facility ever had unannounced inspections, or did the staff all know that the inspectors were coming beforehand?

Ms. ELLIS. No; there was never any unannounced visitations by the State. Every time that anybody came, we were notified several weeks ahead of time, if not several months, and then there is also a group of parents and citizens who volunteer to go around and visit the homes, and it's called AIM, and they are paid volunteers. But they are supposed to come unannounced, and they call up and let them know, so then as soon as they have knowledge that these individuals are coming everybody rushes around and makes sure that they have got everything in order, and of course the staff are on their best behavior, and you don't really see what is really happening in the homes themselves.

Chairman WYDEN. Is it correct that under Oregon State law, all a provider has to do is pass an initial inspection and from that point on the provider merely has to give the State a written check-off list stating that the provider is complying with the law to keep its license?

Ms. ELLIS. Yes; at this time, they have this self-monitoring system now. In the past, there were on-site investigations, and they would come, and they would let you know that they were coming, and you knew months ahead of time, and you prepared for their arrival. But now they have a system where the provider themselves, they will do their own monitoring. They can fill out the little slip, check out what they want to, and they can say whatever they want on that form, and send it in, and that is what the State will accept.

Chairman WYDEN. That is the current law in Oregon?

Ms. ELLIS. Currently, yes; it is just new.

Chairman WYDEN. So, in your opinion, current law permits self-certification and widespread use of announced inspections, thereby making it less likely to get an independent assessment of what is going on?

Ms. ELLIS. Absolutely.

Chairman WYDEN. Does Oregon require ongoing training for individuals? Are employees meeting the State requirements?

Ms. ELLIS. They do require, but that doesn't mean that they are meeting the requirements. There is to be in-service training, and some providers tout that they provide 32 hours per year of in-service training for the staff, but I would venture to say that if you went and you checked their personnel records you would see that obviously is not happening.

Most of the time, the provider's statement is that there is no funding available for that, and, again, there is your high staff attrition, you have a high turnover of staff, and they are not really willing to invest much money into training, and there are many people who never have any preservice training at all, and they are just placed right on the job. It's not just one provider, it's a State-wide problem, probably a nationwide problem.

Chairman WYDEN. I have generally heard that case managers face a very, very hefty workload in some instances. Is it true that case managers often inscribe on the records a statement that services are delivered that have not been delivered?

Ms. ELLIS. Absolutely. During my employment with the last agency that I worked for, a case manager had signed off that a number of these things had been completed, that they were, in fact, there, when, in fact, they weren't. They do have a heavy case load, and visitations are far and few apart unless there are problems.

Chairman WYDEN. Mr. Medonis, let me go back to you. You talked about the falsification of records early on. Were those financial records and service records, or were they primarily financial records?

Mr. MEDONIS. No; these were strictly financial records.

Chairman WYDEN. Just financial records, unlike the situation that Ms. Ellis was talking about.

OK, Ms. Ellis, that was very helpful. We appreciate your being here as well.

Ms. Carson, you asked for a budget for services provided to your son repeatedly?

Mrs. CARSON. Yes.

Chairman WYDEN. You were unable to get it?

Mrs. CARSON. Yes.

Chairman WYDEN. You brought that to the attention of State officials?

Mrs. CARSON. I sent them letters also.

Chairman WYDEN. What was their response?

Mrs. CARSON. Well, it was just like a ping pong game. They say Mental Health has those records, Mental Health says the provider has it, and back and forth you go until when the president of this company came to town. Our advocacy group went as a group and kind of cornered him and said, "We need accountability here," and he was not able to give us that either, although he had Bass Computer Systems supposedly linked up with back in Michigan, but he promised that information on that day. We never did receive it, and to this day we haven't received anything, and I've sent certified letters.

Chairman WYDEN. With respect to the matter of the adverse reactions your son had to new medication, are you saying that the people who worked at the facility didn't have the training and the experience to recognize those problems?

Mrs. CARSON. Yes; my son's situation was that he had become so distrustful of the staff and the provider as a whole that he became kind of a recluse and would not allow staff in. So, this did make it a bit of a problem for them to monitor him, although it could have been done if it had been done right, and in very hot weather he

was put on a new medication that—I, in fact, brought them the medication insert, to watch for these different symptoms, and I said, "Please be aware, in the hot weather he does need to have adequate liquids," and they didn't do this. They opened the door, and he fell on the floor and was having a seizure. He has never had a seizure in his life, but it was brought on by this.

Chairman WYDEN. On the matter of the vocational training program, I gather that the State spent considerable money and effort, but you felt that the program was very deficient?

Mrs. CARSON. Very deficient. It was a joke. They did place Doug in several different jobs, but there was no ongoing—they didn't follow through, and then when they felt that jobs weren't out there, they just started taking them to social things, restaurants for coffee or whatever, to put in their time basically that they had to spend with a client.

Doug and I fired them. We just said no, the State is wasting a lot of money on this, and we're not going to be part of it.

Chairman WYDEN. With respect to your losing your job as an advocate for those who are mentally retarded and developmentally disabled, did I understand you to say that you were told that it was not a question of your performance, that you were up to the professional standards that were required, and you were a good advocate?

Mrs. CARSON. That's why they hired me, because of my background of being a staunch advocate.

Chairman WYDEN. But it was other considerations that led to your firing?

Mrs. CARSON. Yes; on my fourth day on the job, which was a Thursday morning, I spoke to my supervisor and told her that I wanted to keep her updated as to what was happening with me, and I said I had been called by the Detroit Press and was interviewed by a reporter regarding a situation, and also that I would be called to testify in the case for Ms. Ellis, and within an hour she had come back in the office and said, "Well, I think we'll just mutually agree that you have conflict of interest problems and that you probably shouldn't stay at this job."

Chairman WYDEN. Were you told what the conflict of interest problems were?

Mrs. CARSON. Well, basically, my involvement with community issues regarding ASI, apparently, because she had gone and made telephone calls, and I know for a fact that the mental health administrator for the State of Oregon made phone calls as soon as he found out that I had been hired, letting them know that he wasn't too pleased with that situation. Also, the provider made a phone call doing the same.

Chairman WYDEN. I'm going to follow up on these matters because it is especially serious when people are doing their job advocating for those who are really powerless in our society.

Mrs. CARSON. Exactly.

Chairman WYDEN. This subcommittee takes a pretty dim view of advocates being unfairly sanctioned when they speak up. We will follow up on this. We want you to know we really appreciate both of you coming from Oregon. We also appreciate the Oakes and the people from Massachusetts.

It is really striking that this table spans 3,000 miles from Massachusetts to Oregon, and there are many parallels in what you are saying.

Ms. ELLIS. If I could just add one thing?

Chairman WYDEN. Please.

Ms. ELLIS. I wanted to say that the day that we had come to meet you at the Town Hall meeting, that was the day that we were being stigmatized. I mean the provider has found out that we had attended the meeting; that a couple of the clients that were at the meeting, they met you and your aides; and that was when we were threatened with arrests, with restraining orders. The clients were told that we were bad influences on them.

Mrs. CARSON. They were denied access.

Ms. ELLIS. They were denied access, absolutely, to you, to us, to anyone, and I happen to have been, as a program manager—it was my job, it was my life, and these were the people who I really cared about.

I was told that I couldn't see them, and I did not make contact to them. They called me, and then I was penalized. I was stigmatized because I answered my phone. I was left at this point where I had no control. I couldn't do anything for them except, "Please, I don't know what to tell you. Call Oregon Advocacy."

Here, at Oregon Advocacy they are supposed to be working for them, but you have got people who serve on the board at Oregon Advocacy and Mental Health Division, and they are all serving on one another's board of directors——

Mrs. CARSON. They overlap.

Ms. ELLIS. They all kind of pat each other and nothing happens. It is very scary.

Mrs. CARSON. It is.

Ms. ELLIS. Then people find out, your fax numbers and how did they get it? The provider who is after us finds out a private number and sends a fax.

There is something wrong. There is something really wrong with this system, and there needs to be some kind of assurance and quality, to these people's lives.

Mrs. CARSON. They have no security.

Chairman WYDEN. Both of you raise some very troubling concerns. I am going to have to do some followup with respect to the situation you faced, Mrs. Carson, and the action that was taken, against you Ms. Ellis, at your facility. These are issues that are certainly going to take some followup.

But, shoot! If you hear about homes that know about the inspection before it is coming, and if you hear about a process that involves self-certification where, in effect, a home can designate itself as meeting all the standards, that simply doesn't meet the test of good professionalism by any calculus.

So, I am going to do a lot of followup on the kinds of situation that you both have described. As I say again, this table spans concerns, literally, of folks over 3,000 miles. We will pursue these concerns very vigorously. We want to be in touch with all of you.

We will excuse you at this time.

[A chorus of "Thank you, Mr. Chairman."]

Chairman WYDEN. The next panel: Mr. Thomas D'Luge, Alternative Services, Inc., Montana Clemmons, Michigan; Mr. Ralph Farkas, New York State Disabilities Council; Ms. Bonnie-Jean Brooks, vice president for policy, National Association of Private Residential Resources; Ms. Toni Richardson, commissioner of the Department of Mental Retardation, National Association of State Mental Retardation Program, Hartford.

We are going to swear all of you in and go through the formalities. I think many of you have been here throughout the morning. It is a practice of the subcommittee to swear the witnesses.

Do any of you have any objection to being sworn as a witness?

[No objection.]

Chairman WYDEN. Please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. Let me advise you, ladies and gentlemen, that I am going to have to adhere strictly to the 5-minute rule for testimony at this point or we are going to be here until dinner time, or breakfast time tomorrow. We will make your prepared remarks a part of the record in their entirety.

If you would like to furnish additional information after the hearing, it will be made a part of the hearing record in its entirety. Therefore, your full comments will be a part of the record.

Chairman WYDEN. Mr. D'Luge, welcome.

TESTIMONY OF THOMAS D'LUGE, ALTERNATIVE SERVICES, INC.

Mr. D'LUGE. Mr. Chairman, committee members, I wish to thank you for having been given the opportunity to participate in this subcommittee hearing. Only through this and other similar forums will we be able to collectively gather the necessary insight to both critique the current system and develop new and challenging measures of performance for the normalization concept.

The field of community placement is relatively new. This experiment generally started from the mid- to the late 1970's. Some States' first encounter with community placement was as a result of judicially mandated, deinstitutionalization decrees. This type of forced community placement, although necessary, faces a more difficult path to its goals as it sometimes is met with local or State resistance. Under these time constraints, the local or State agencies are required to develop both clinical and financial regulations to set up and monitor community placement providers.

These clinical and financial guidelines generally reflect existing State or local regulations being interweaved with Federal regulations. Some of these regulations are inconsistent. Some of these regulations are interpreted and enforced in a discriminate manner by agencies having dual overlapping responsibilities. Consistent with the growth of community placement has been the downsizing of mental health divisions, particularly in the institutional field. A portion of the inconsistencies in regulations and enforcement can be traced back to sometimes voluntary, sometimes not, reorganization of people and departments as a result of community placement.

When one contemplates the enormity of these departmental changes in a scientific field based on nonconformity, we can only

marvel that the system has performed as well as it has. The field of MDD exists because we have a population that generally, through no fault of their own, do not understand all of the facets of social conduct and, therefore, by law may not be accountable for their actions. Under this scenario it is, therefore, inappropriate to set expectations that the system perform without error.

Now, you might concur with this concept but question the roles of others within the community placement field who are or should be accountable for their standards. Their conduct has been questioned, and they are held to more demanding standards as the monitoring process constantly analyzes and upgrades its procedures. The various State and local monitoring agencies know their job and have adequate regulations in place to monitor all aspects of the community placement field.

To the extent that there are shortcomings in the regulatory process, we believe that they can be traced primarily to inconsistent standards and inadequate funding within the enforcement areas. There are, and will continue to be, some level of client and financial abuse so long as the system requires human beings for its operations. Instances of abuse occur in every aspect of life from our churches to our schools to our family structures. Now, that doesn't mean that we in any way condone such activities, but we believe it is important to establish the fact that just because abuse occurs that the system should be abolished. You don't throw out the baby with the bathwater.

We believe that the real issue before this committee is to minimize such occurrences. To accomplish this goal, we must do three things: Increase the number of people working in this field; improve their compensation level so that you can attract a more dedicated worker; and last, but not least, provide funding for additional training. In my written testimony, I have referred to a review of wage scales for direct care workers contained in residential services and developmental disabilities in the United States.

A National Survey of Staff Compensation, Turnover, and Related Issues, as prepared by the Institute of the Study of Developmental Disabilities of the University of Illinois at Chicago, confirms on a national, State-by-State basis the findings of our own studies. The findings established the average compensation paid to community placement workers is at or near poverty level. Furthermore, the average wage paid to a State employee substantially exceeds that paid to direct care workers in community placement for similar work.

In fact, one of our own surveys compared the per diem State-operated group home compensation levels with group homes caring for clients by individual providers. The local agency approved per client per diem rates for those homes was 34 percent higher than that approved for the other nonprofit providers in that region. These statistics are worsening as many States, during the recession, have either frozen or cut budgets over the last several years. This has resulted in the problem with high staff turnover continuing to multiply. Except for the very few who are sufficiently talented to move up the ladder, few, if any, direct care workers can raise a family on their pay scale. Consequently, the field is full of part-

time or temporary employees who leave the field at the first opportunity.

Our own studies, based on exit interviews, confirm that over the last 2 years resigning employees cite insufficient pay as the basis for resigning at a rate of 50 percent greater than that just a few years earlier. What are we to do?

President Clinton has acknowledged and stressed the need for this country to invest in its future. We need to invest in our people through jobs and training skills. Our infrastructure has been cited as a need for concern in job growth. Are not our own people building blocks for this infrastructure?

Funds spent in the community placement are not temporary. The employees don't leave town when the roadwork is completed. We believe this committee, consistent with its purposes, will acknowledge the success of this field and its peril if further and adequate funding is not forthcoming.

I wish to thank you for all of your kind attention and any further questions that you may have in regard to this area. Thank you.

[Mr. D'Luge's statement, with attachments, may be found in the appendix.]

Chairman WYDEN. We will have some questions for you in just a moment.

Mr. Farkas, welcome.

TESTIMONY OF RALPH D. FARKAS, EXECUTIVE DIRECTOR, PROFESSIONAL SERVICE CENTERS FOR THE HANDICAPPED, INC., AND CHAIRMAN, NEW YORK STATE DEVELOPMENTAL DISABILITIES PLANNING COUNCIL

Mr. FARKAS. I am an executive director of Professional Service Centers for the Handicapped, in New York, and in my other function I am also the chairman of the New York State Developmental Disabilities Planning Council. I kind of was asked, in essence, to testify using my two hats, so, if it somewhat sounds a little bit disjointed, my testimony, it is due to the fact that I do have those two hats, and they do kind of represent some of the separate missions, but in the same time probably the same missions, which is to provide services to people with disabilities in New York within a community-based system.

Just a little bit about PSCH. Professional Service Centers for the Handicapped is an organization that had come about in about 1980 and is now providing services to more than 1,250 individuals on a given day in a variety of different services from ICS communal residence for the mentally disabled as well as substantial programs for people with psychiatric disability in communal residences, work support programs, day treatments, and the like.

In New York in the past month we have rather celebrated momentous occasions, the closing and satisfaction level of the Willowbrook consent decree where the plaintiff and the defendant have agreed to suspend that particular litigation and bring about the actual completion of this litigation. We feel that in New York many of the issues that have been discussed and described, we have taken some steps to curtail. For example, in New York, the rule for

visitation to communal residences are all unannounced as per rule as a standard rather than a matter of compliance.

We, in essence, are trying now in New York State under the home-based waiver to look at how we can move those services from institutional based to community based services, and there is a kind of difficulty as we look at some of the language and some of the issues that we are discussing today, specifically when the services that we are talking today are regarding to the individual service plans, the ISS, those services that are supposed to go directly toward that person.

The question that really confronts a provider as well as the State is how do you provide the kind of service to the individuals and at the same time you bring their accountability, their fiscal accountability, and in the same time how do you bring the kind of services that individual deserves. In New York State, my agency has tried to do a couple of things. Under the Department of Labor there was a grant under EDWA, which is the Worker Assistance Act—one of the things that we have tried to do as an agency is to try and to relearn, reteach individuals from different industries.

One of the things that we found, and it is historically in New York, is that we had a great deal of difficulties, particularly in the eighties, to recruit individuals. When we started originally in the eighties, our managers and supervisors were all master level and BA level. As the eighties came about, more and more we were losing more of those individuals, and we started looking at less qualified, less educated individuals.

In essence, what we started to realize is that unless we are going to bring in individuals who are qualified and trained, we are going to have a disaster on our hands. Our agency, in essence, what we started doing is to develop a training department within our agency and start to look for other means where there will be the university-based or whether in State-based programs. But we found, essentially, there wasn't any. There is not one university that would bring in an actual BA or AA degree, a formal degree, where we can go in and, as a partnership, develop actually a degree for people in this profession. It is the value that we put in the people who work in this field. It is that value that translates also to the reimbursement rates of the individuals who are coming.

We found in a study that was done by the council in New York State that universally people are complaining about the cost and the reimbursement, but that is really not the predominate reason that people leave this field. One of the areas that it is important to say that it is predominately women who essentially do not get the same compensation and the value of the women working in this field. Consequently, that translates into the kind of reimbursements that the organizations have made.

So, on one hand we have a very, very vulnerable population that we are supposed to provide quality services. On the other hand, there is the regulatory requirements and the lack of reimbursement rates that in the same time expect that those two things will match. One hand, we don't recognize them. Another hand, we say they are the most vulnerable population, and you have to do everything in your power to do so.

I think it is important in a State like New York, and any other State in the Nation, that organizations' financial pictures are strong. I know in New York State, as a rule, we do not have proprietary organization. All of the services that are provided for DD are run by not-for-profit 501(c) corporations, and the support within the partnerships between Government, the consumer, and the provider is a key for any kind of success. I don't think that we should be pitting one group versus another. I think that what we need to do is, essentially, bring the three or the four pieces of that equation in to the table and discuss how we can provide services.

Thank you very much.

[Mr. Farkas' statement may be found in the appendix.]

Chairman WYDEN. Thank you.

Ms. Brooks.

TESTIMONY OF BONNIE-JEAN BROOKS, VICE PRESIDENT FOR POLICY, NATIONAL ASSOCIATION OF PRIVATE RESIDENTIAL RESOURCES

Ms. Brooks. Good morning, Chairman Wyden. I am Bonnie-Jean Brooks. I am here from Maine, representing the National Association of Private Residential Resources, as its vice president for policy.

Before I go further, I want to mention to you that I believe you have somewhat of a local expert on your panel when it comes to life in a community residence, and that is Representative Andrews from Maine. Perhaps you know he has actually lived in and worked in a community residence with people with disabilities, and I am sure he will share some great insight with you.

I am also guardian of a woman with severe and multiple disabilities who lives in a nonprofit agency in Maine. I also wear the hat of executive director of OHI, which is a nonprofit agency in Bangor, Maine, that primarily serves people with the dual diagnoses of mental retardation/mental illness who have previously been institutionalized over most of their lifetime prior to my having come to meet them and to provide supports and services to them.

I am going to use some demographics and experiences from my own agency that I think represent other members of my national association throughout the 50 States. My own agency since 1979 has assisted over 100 people with these dual diagnoses to move from an institution into the community. In addition to providing direct residential supports, we assist individuals to buy a variety of other supports and services from a host of other small Maine businesses like merchants, clinicians, the entertainment industry, and so forth.

We employ over 160 people in 8 rural communities around Bangor, and we have an annual budget of about \$3.5 million that contributes to those eight rural economies. Over the years, we have fully supported and implemented individualized living opportunities for people with severe disabilities and reputations, and we believe we have been remarkably successful as a small business in achieving high quality as defined by the customer, the person with

the disability, and his/her family, as well as by the Maine Bureau of Mental Retardation.

We have defined our success by the high rate of permanent deinstitutionalization, as mentioned previously; the significant decrease in cost to State and Federal taxpayers for the services and supports that we provide these individuals who are now living free of institutions; and by, most importantly to me, what these individuals and their families tell me about their satisfaction level with our services; and last, by many examples of these individuals contributing to the community by working and being a part of the work force.

We have announced the closure of our one mental retardation institution, Pineland Center. It has less than 180 people there, and I am happy to say that our State Legislature and Department of Mental Health and Mental Retardation have made a commitment not to fund a 2-tier system. So, as that individual moves from the institution, money will move from the institution, too, so that there can be the adequate resources there that the community needs in order to not fail the people who move from the institution.

The current annual cost for one person to live at Pineland Center is about \$124,000. The annual average cost to live at the agency where I live, where people have come from Pineland Center, is about \$66,000, including day or work programs. That means there is a span in my agency per annum from \$16,000 to \$98,000 but that the average is \$66,000 in comparison with Pinelands' \$124,000. That is a savings to the State and Federal Government for every individual to whom we provide services, of about \$57,000. We serve 58 individuals with a dual diagnosis, and that means that there is a savings to the State and Federal taxpayers annually of \$3,306,000 for these people to live at OHI rather than Pineland. If we compound that over the 34 years that Edith, who was mentioned in our written testimony, lived in the institution, by the other 57 people living in OHI, that means that over their collective lifetimes had they each lived 34 years in the community we could have saved taxpayers \$191 million.

Small community businesses serving people in an individualized manner makes both economic and ethical good sense in addition to best assuring people all of their basic freedoms. However, there are definitely proper techniques, strategies, protocols for accomplishing this task in the accountable manner that you and I both want it accomplished in. Although we are reviewed, regulated, surveyed, monitored, inspected, accredited, and audited by a great number of enforcement agencies that try to assure the health and safety conditions, there are other markers that, in combination, better assist consumers, families, governments, and the community to find out who are the businesses of excellence and what are their marks.

They include looking for the mission and the philosophy of the organization; the role of the customer and the family in the agency; the visibility and involvement of the leadership; the effectiveness of the internal quality assurance program; the standards that are set and implemented through policies; I might particularly stress since it seems to have been a focus here today, policies that relate to abuse and neglect, exploitation, and mistreatment. I have my own agency's policy here, and I would be most happy to share

it, because it has, I think, some great ideas and some good assurances.

Through training, which has been stressed, and documentation, and the involvement of the community, looking at people like me frequently, to mention only a few ideas. I am ready to provide an expanded list of recommendations to you. The challenge posed by your seven questions is overwhelming and the answer is worthy of further future significant discourse, elaboration, and investigation, well beyond my frustratingly short 5 minutes.

I have personally spent 28 years of my life addressing these very questions. With my national organization and our members, I would like to work with you to identify the barriers to cost-effective services that promote customer satisfaction.

In summary, small businesses providing services and supports to persons with disabilities in American communities in small homes in a manner designed by the customer with oversight from families, the community, and others makes sense from all perspectives and will ultimately provide the best assurances. I welcome any questions from you about the matters that trouble you most.

[Ms. Brooks' statement, with attachments, may be found in the appendix.]

Chairman WYDEN. Ms. Brooks, thank you very much. That is very helpful and useful testimony. We appreciate it.

Chairman WYDEN. Ms. Richardson.

TESTIMONY OF TONI RICHARDSON, COMMISSIONER, CONNECTICUT DEPARTMENT OF MENTAL RETARDATION, ON BEHALF OF NATIONAL ASSOCIATION OF STATE MENTAL RETARDATION PROGRAM DIRECTORS

Ms. RICHARDSON. Thank you. My name is Toni Richardson. I am the commissioner of the Connecticut Department of Mental Retardation.

I appear before you today as the spokesperson for the National Association of State Mental Retardation Program Directors. Members of this Association are the chief State mental retardation and developmental disabilities officials in each of the 50 States and the District of Columbia. Collectively, we are responsible for furnishing a wide variety of supports and services to some 500,000 people with mental retardation and other developmental disabilities. We are pleased to be here today to address the vital topic of State management and oversight of community residential programs.

I don't want to respond in any way to direct concerns about particular States' performance, but I would urge you to talk directly with the Mental Retardation/Developmental Disabilities Program directors in those States, if you haven't already done so.

Over the past 10 years, the lives of people with disabilities have changed dramatically, and so have the ways in which State governments support their lives. From the era of large, publicly operated institutions, we have moved to more diverse and decentralized community-based supports and services; to make this transition we have had to forge public-private partnerships that allow us to take advantage of the thousands of not-for-profit organizations with community experience and connections. In the process, we have

learned ways of preventing abuse, neglect, and exploitation, while promoting inclusion, crafting options, and individualizing our service approaches. But we still face numerous challenges in overseeing diverse and rapidly evolving service systems.

Quality assurance is an uphill battle, as I think you have said. We don't pretend to know all the answers, but we are learning from our successes and failures as well as from the struggle that many of us spent a lifetime engaged in. You are right, agencies and personnel must be competent and motivated. Health, safety, and appropriate supports are critical. So is financial oversight. Even with the kind of fairly complicated financial oversight that we use in Connecticut, I am still not content that we do enough to monitor the financial affairs of our contract agencies.

Some traditional regulatory oversight is necessary, but family, consumer, and citizen involvement is equally vital. Such involvement is sometimes uncomfortable. It is today. But it is welcome nonetheless, and we, as public officials, have to learn to be better listeners. Sometimes the difficulty of the issue and the emotion of the moment put us off. It must not and it cannot. So, a positive strategy, aimed at preventing problems rather than punishing bad results, should be our objective.

Mr. Chairman, I think you made this point as well. A combination of monitoring strategies are necessary, some looking at outcomes, some looking at process. Multifaceted strategies work best. Problems will arise, and, when they do, we must be able to act swiftly and decisively. But day-to-day problems should not overshadow the enormous successes that have been achieved in community-based, developmental disabilities services.

Over the past few years, our Association has proposed strengthening the Federal-State partnership in promoting high-quality services. The community supported living arrangements coverage option under Medicaid moves in the direction we have advocated, encouraging departures from a total reliance on traditional regulations and involving a range of citizens, consumers, and families in the quality building process.

Good quality costs money. Federal matching of quality assurance and enhancement dollars for community programs would be an enormous help.

Turning to the subcommittee's specific questions, I will comment briefly on the written answers we have given you. On the first question about where providers come from, the number of for-profit operators is, by all accounts—at least all the accounts I am familiar with—quite small. The not-for-profits predominate and the largest part of their financing, of course, is derived from public agencies. With regard to multi-State providers, in Connecticut we have 135 private organizations doing business with us, and we see some real competition for development opportunities. Even so, we still prefer to improve rather than remove providers in order to avoid disruptions in the lives of our consumers and their families. But we do remove providers when necessary through licensure action, contract cancellations, or by mutual agreement. I think you will find, if I heard the testimony of the gentleman from Massachusetts correctly, that the provider which was doing business in Connecticut

when the Massachusetts investigations were being conducted is no longer in business in Connecticut.

Quality assurance improvement was the focus of your third question. Investment in quality enhancement gets a better return than investment in quality policing, I find. While some traditional monitoring is necessary, the focus of development needs to be on improving services quality. Like they say in real estate, "The most important thing is location, location, location." Well, in quality, it is improving, improving, improving.

Question four dealt with the locus of oversight responsibilities. In community settings, everything is more mobile and less given to precise timetables. An everyday lifestyle is, after all, what we are trying to achieve for our consumers, so monitoring must happen at different times and in different ways. That necessitates a substantial, flexible, and mobile approach to quality monitoring.

Question five involved quality assurance methods and processes and asked if current practice is keeping pace with the expansion of services. I think they are, but the person power isn't. We need to do more followup, especially in the area of financial auditing.

Question seven, training and background checks. The level of reporting and the available information concerning histories of abusive behavior in adult services does need to be improved. It is not nearly so well developed as information in child protective services, for example. Progress in employee training initiatives is mixed. Some training programs are excellent, and the values training in particular which is taking place is excellent, but monitoring of the quality of training has a way to go.

Compensation was question eight: Is it adequate? The answer is a resoundingly no, particularly in States that are still struggling to pay minimum wages. In Connecticut, thanks to a boom economy several years ago, we were able to take corrective actions and, as a result, we are not doing so badly. Still, there is a fairly wide gap between what we pay State workers and what we pay private workers for the same types of work.

The ninth question was about parents and family. As I have said throughout my remarks, their involvement is critical as part of a team that includes the individual to be served—as advocates and critics, as quality monitors, and as program developers.

I want to thank you on behalf of our association for the opportunity to testify before you today, and I will be happy to entertain questions.

[Ms. Richardson's statement may be found in the appendix.]

Chairman WYDEN. That was very helpful, Ms. Richardson. I want to begin with you. All of you have been helpful in cooperating with the subcommittee, and we desire to work with you. Clearly, there is much to be done, as I have tried to emphasize. I am of the view that there are a great many good facilities in this country. That is not in question.

What is in question, as Mr. Medonis from the State of Massachusetts mentioned, is systemic blind spots. He talks on page 2, and I quote, "Systemic blind spots have allowed certain providers to engage in illegal activity," and he goes on to discuss the various kinds of blind spots.

What we wish to do is work with all of you to deal with some of those blind spots. Let me get your thoughts on some of them. I am particularly interested in knowing whether you think some of the matters I am talking about are isolated cases or are they more widely prevalent.

For example, Mrs. Carson talked about parents' inability to see a budget for the services provided for her son. I asked Mr. Medonis about that specifically. Mr. Medonis said that this problem is widespread. In many instances, parents and families were unable to see budgets for services provided to a son or daughter, in a home.

Ms. Richardson, is that the case? Is it common that the parents of a person in a facility for the mentally retarded or developmentally disabled is unable to see a budget for services?

Ms. RICHARDSON. I would say that the experience across the country is rather diverse. Different States require different kinds of information, and they compile that information differently. I would suspect that in a State that has not yet automated and computerized their budget information, it could be somewhat difficult. If a provider wanted to keep that information from a family, it might be fairly easy for them to do that.

On the other hand, where States have required that budgets be filed annually and that audited documents be on file, it should be possible to make such documents available. They certainly are in Connecticut.

But whether there is some difficulty that people have in sharing budget information and whether we need to make sure that such information is available is something that I would say is open to question.

Chairman WYDEN. Well, I am interested in your followup on that. If we are really going to strengthen the system and do it in a cooperative way using a Federal-State partnership, we have got to pick up on trends.

Mr. Medonis said that people are unable to see these budgets everywhere. Why don't you, in followup, try to get us an assessment of how frequent that problem is. This also relates to a view that Ms. Brooks talked about that I also share. If we are going to really strengthen the system, we must involve families and loved ones much more extensively. It is pretty hard to involve families and loved ones if they can't see a budget. I would like to have further analysis on that point.

Now, in addition, Mr. Medonis, in his testimony talked about the inability to deal with companies and individuals moving from State to State causing problems. Is that a problem that is widespread, Ms. Richardson? I got the impression from Mr. Medonis that is a widespread problem.

Ms. RICHARDSON. I need to ask for clarification of that question. Are we talking about individuals who perpetrate abuse or are we talking about providers who—

Chairman WYDEN. Mr. Medonis told us that people who had been convicted in Massachusetts were operating somewhere else. They said that was the case in seven States. In five States, the U.S. Justice Department and Mr. Medonis' office were cooperating in an investigation. That strikes me as being in line with the systemic

blind spots that Mr. Medonis talks about in his testimony. I am interested in knowing whether you think this is a problem.

Ms. RICHARDSON. Fair question. On the issue of individuals, I think it is difficult to identify, in advance, potential perpetrators of abuse. Unless a State goes to the effort when they perform a police check of checking not only their own State's records for convictions but the records of other States—which is a more expensive proposition—you are not going to turn up the fact that somebody may have committed an act of abuse or crime in another State.

I think the difficulty and frustration, quite frankly, is that even if you do the most comprehensive background investigation, nothing may show up; yet that person may have worked in several different States and been discharged or reprimanded for abusive activities. But unless such activities were the subject of a successful criminal prosecution, they are very unlikely to be uncovered by background check. So, once the person leaves that State, there is just no way to keep track of his or her past history of abusive behaviors. That is a worry. That is a genuine worry.

As far as organizations are concerned, there is no formal network for checking on the performance of a provider in other States, but I think it is more possible, informally, to determine an organization's past track record. We certainly, for example, ask prospective new providers to disclose where else they are doing business, with whom they are currently doing business, and with whom they will be doing business while in our State. Where there are indications that an arm's length relationship may not exist between the provider and other closely related corporations a provider fails to disclose such information and we discover it, we have authority to investigate or levy penalties for such behavior. That turns out to be pretty useful. I might add that certain actions we took in Connecticut as an outgrowth of the Massachusetts investigation were the result of checking the disclosures made by a corporation that was engaged in business in both States.

Is it a problem? Yes; it is. Are there some things that make it less of a problem than the situation with individuals? I think so, because I think it is easier to catch up with large corporations than it is to catch up with individuals.

Chairman WYDEN. Well, I am sure that is the case. I found it very troubling when Mr. Medonis and his colleagues told us that people who are found involved in illegal schemes in Massachusetts were operating homes in seven other States. I gather you also find this troubling?

Ms. RICHARDSON. I do, indeed.

Chairman WYDEN. Mr. Medonis also mentioned shell companies as being a serious problem. Do you share his view that this is a serious problem, or is this something that is so isolated that this committee and Congress shouldn't care about it?

Ms. RICHARDSON. I think that is something to be mindful of. We haven't had extensive experience in Connecticut with this problem so far. We have shared an experience with Massachusetts regarding one particular company. As I say, that company no longer does business in Connecticut. We all need to be mindful of the fact that those kind of financial shenanigans are certainly possible, and, con-

sequently, we have to put in place rules to prevent such occurrences.

Again, having established rules that require disclosure, we have run into few problems of this type. Anyone who doesn't disclose, we simply don't reimburse them for the particular service. That rather solves it. Nonetheless, I think it is something to be mindful of, especially if we see a further growth in large multi-State providers.

Chairman WYDEN. I was also told this morning that there is a problem concerning self-certification. Homes can, once they get their license, simply fill out a little checklist and say that they have met all the standards. Is this common practice?

Ms. RICHARDSON. The use of self assessment tools is growing. The whole complex issue around how to monitor and monitor well, but not intrusively, so as not to interfere in the lives of the people who we are trying to protect, is the certain issue here. States are experimenting with a whole variety of different ways of accomplishing this objective. The one you mention is an approach where providers periodically fill out a compliance checklist which they forward to either the State agencies or their local county agencies. The information supplied by the provider is compared with other pieces of monitoring information, coming from case managers, families, advocates, licensing, and other sources. All of this information is combined to establish a comprehensive picture of the provider agencies performance.

I think it is an interesting approach. I can understand why people would have reservations about it. But without experiencing it, without having had that opportunity myself to use self assessment checklists, it is hard for me to evaluate this approach completely, except to say that at least it offers some possibilities for collecting rather routine information without mobilizing a force to do so. But it is no substitute for people visiting and seeing what is really going on within a program or facility.

Chairman WYDEN. How about unannounced inspection? Are these common in the field?

Ms. RICHARDSON. I think unannounced inspections are fairly common. The difficulty, though, to be very candid with you, is that the minute someone decides to do an inspection on a given date, the walls have ears and somehow that information gets out. I have this frustration in my own State with trying to send an investigator out unannounced and yet somehow people know they are coming before they get there.

The only way I have ever found to do an unannounced survey is just not to tell anybody—and I mean anybody—and just appear on the scene.

Chairman WYDEN. Well, what is wrong with doing it that way?

Ms. RICHARDSON. One of the problems you find is that if the objective of your visit is to review certain information and to ask specific questions, then it is entirely possible that the people you wanted to talk to won't be there when you arrive. That presents problems.

In this day and age, all the consumers and their supporting staff members may be at the movies, and so you have just paid to have an inspector to complete an unannounced visit, and there is no one

there. Those are realities of trying to orchestrate unannounced visits.

I think, as we are making progress in incorporating in our quality assurance systems, lots of different sets of eyes looking at what is going on with an individual. As we do this, unannounced inspection become less of an issue, and I think maybe they should. If we have people moving around interacting with the individuals we are trying to serve, we get a ton of information from those people, as long as we are open to receiving it and as long as we are encouraging such input. I think that this approach helps to further the quality assurance process a great deal.

Chairman WYDEN. Let me move on. You have been very helpful. We are going to work very closely with your association.

Ms. Brooks, we also heard about Mr. Medonis' concern about board meetings not being taken seriously or being held extremely infrequently. Do you share this concern? Is that something that is common, or is it an isolated problem?

Ms. BROOKS. In my experience, the nonprofit agencies I know have board of directors, and those board of directors meet on a regular basis. I have known of situations where boards—I heard of boards meeting as infrequently as every 6 months. I have heard of that in one case. But that is not the rule; that is the exception. He also mentioned small boards as something to look out for. I have a grave concern about a small board. I think in Maine, the smallest you can have a board is three people. I would be very concerned about that.

I think the average board I know about is about 10 people, and I think that people meet generally at least monthly, and there are a lot of mechanisms for holding the company accountable.

Chairman WYDEN. What if the Federal Government worked with your organization and with Ms. Richardson to put in place basic core standards for running quality assurance programs? Would that be a useful cooperative effort between the Federal Government, the States, and homes like yours?

Ms. BROOKS. Yes; if the Federal Government decided to develop any more standards than it has already developed or change some of the existing standards, then we would very much welcome you working with our national organization. I also would recommend that if you are going to be working on the development of quality standards, you take a look at some of the quality standards that have been developed by ACD, the Accrediting Council, because they have been giving a lot of thought and energy to this in the past 18 months.

Chairman WYDEN. So, what you would like more than anything else is a consistent baseline for quality assurance? You would like the Federal Government, the States, and these accrediting bodies to all be brought together to define this core set of standards or baseline approach?

Ms. BROOKS. Truly, I think that the quality of one's life can only be defined by one, and therein lies a serious problem. I think that is what accrediting bodies have been moving toward, to assurances that quality will be defined, quality will be assured, but that it will be defined in the realm of the individual and will not put all individuals into one box.

Chairman WYDEN. I think that is a valid point. I have tried to emphasize that no one has ever said you could mandate one set of rules with a cookie cutter. But when you hear this testimony about announced inspections, self-certification programs, shell corporations, and people not being able to get budgets, you become concerned. These things go to the heart of our concerns over good care, careful spending of Federal and State dollars.

While I share your interest in measuring quality through the prism of an individual, we also need some other measurement tools. Mr. Farkas, let me make sure I understand the position of your organization. You would like to have more extensive tools to deal with the kind of frauds and the kind of problems that we have seen this morning?

Mr. FARKAS. Well, some of the areas, for an example, of the evaluative tools when you review an individual and its environment, it is critical. Our experience, for an example, in Federal audits, if you will, is that we are extremely paper and concrete oriented where what is in existence for an example, rather than how does that relate for the person's quality of life.

I think we are more interested in seeing how that individual experiences their capacity living with their disability. In turn with that is to assure that the organizations that provide the services have the financial integrity and the fiduciary responsibility to assure that the funds that they are receiving are going to go to those services.

There is a relationship between a good organization that provides good services and good financial standards and their services. Usually, in our experience, if an organization has poor financial records and poor financial reporting processes, they more likely are also going to have poor services.

I know in the State that I am from, which I can only talk to, we spend a great deal of time trying to work with boards of directors throughout the State. The State agencies have a variety of training programs for them, but it is very, very difficult to become a board member, Mr. Wyden. Many times I would approach an individual as a community member and ask, "Would you want to partake in board activities? Would you want to become a board member for a not-for-profit that is serving the mentally ill or those who serve the mentally disabled?" The first thing they ask me is, "Am I going to get sued? Am I going to be liable for everything that is taking place? Who is going to protect me? What are my responsibilities?"

I think that when we are looking at quality assurance for individuals with a mental disability, it is critical to see that the developmentally disabled receive services from a process and the process has an outcome, and that process has a management that has all kinds of a variety of needs that needs to be looked at. So, it is not just a single item or a simple answer.

Chairman WYDEN. Mr. D'Luge, I have just a couple of questions for you. Mr. Medonis raised concerns about problems involving related party activities?

Mr. D'LUGE. Yes.

Chairman WYDEN. Do you think those are valid concerns?

Mr. D'LUGE. Oh, I think that they can be a valid concern, but I do think that they are a very isolated situation. I don't think that

they are typical at all as to any type of national trend regardless as to whether or not it is an agency that just provides services within one State or multi-State.

In fact, what I would suggest as a way of easily reviewing any type of shell situations with related parties is through the Internal Revenue Service audit system. The Internal Revenue Service has actively increased their intervention in the periodic audits of non-profits, as a result of some of the various religious organizational problems that we have experienced over the years, and the number one issue that they look at in terms of any audits is what is the relationship of any related parties and are those services being rendered on a fair market value basis.

So, I believe that you have a method that perhaps through additional assistance through the Internal Revenue Service to increase the timeframes to a more periodic basis but can assure this committee and this Government that, in fact, if there is any type of related party transactions, they are being conducted in a proper and professional manner.

Chairman WYDEN. What is the relationship between ASI, Financial One, Inc., Making Things Work, Inc., and Community Living Concepts, Inc.?

Mr. D'LUGE. Community Living Concepts was incorporated—it is a Michigan corporation, not-for-profit corporation incorporated in 1987. It is a 501(c)(3) tax exempt entity that is set up as a support organization for other 501(c)(3) organizations, such as Alternative Services which operates in Michigan, and Alternative Services which operates in Oregon, and Alternative Services which operates in Connecticut.

Financial One is a for-profit subsidiary owned solely by Community Living Concepts. Alternative Services Michigan was able to develop a fairly comprehensive, sophisticated accounting practices or procedures in the mid-1980's and, as a result of that, a decision was made to remove that from a nonprofit setting and put that into a for-profit format so that it can offer services to other providers.

Chairman WYDEN. Is the president of ASI the same person who is the registered agent for Financial One and the CEO of Community Living Concepts?

Mr. D'LUGE. In terms of who is the resident agent for Financial One, I am not sure. That wouldn't surprise me. Arthur Mack is the CEO of Community Living Concepts and Alternative Services, and he is a board member of Financial One.

Chairman WYDEN. Does Mr. Mack get compensation from all of these various operations?

Mr. D'LUGE. No; just Community Living Concepts. In fact, again that was the subject of—Internal Revenue Service in July and August 1992 conducted a very detailed 3-year audit of all of the various subsidiaries of this entity, and they completed their audit, and they were fully satisfied with the relationship, compensation levels, and all of the transactions between the related parties as being proper and at fair market value rates.

Chairman WYDEN. So, Mr. Mack is president of ASI but he doesn't have a consulting relationship?

Mr. D'LUGE. All the consulting management services are performed by Community Living Concepts pursuant to a contract that

it has with its other subsidiaries. Those contracts are made available to each State. The State has copies of the management services agreement and have accepted and/or approved it—that management relationship.

Chairman WYDEN. But does Mr. Mack get paid as a consultant by either of these other concerns, Financial One or Community Living Concepts?

Mr. D'LUGE. No; just Community Living Concepts.

Chairman WYDEN. He doesn't own stock in the other companies?

Mr. D'LUGE. No. Those are nonprofit corporations, with the exception of Financial One, which has one shareholder which is Community Living Concepts. Making Things Work is also a for-profit entity, which, unfortunately, hasn't been very profitable. But its only shareholder is Community Living Concepts.

Chairman WYDEN. Now, I gather that in Oregon ASI shook up its management team?

Mr. D'LUGE. Yes, sir.

Chairman WYDEN. This was done not long ago. Was this the result of some problems?

Mr. D'LUGE. To say it mildly; yes.

Chairman WYDEN. What were the problems in Oregon? What kinds of changes did you make?

Mr. D'LUGE. Well, there was a combination of problems. Number one, when you go into a State in which there is a significant amount of growth required in a relatively short time period. As you are aware, there were mandated judicial deinstitutionalization decrees which required a substantial number of residents to be placed in a relatively short time period.

Also, Oregon has separate regional authorities which handle the selection of the various clients, and, also, the funding mechanisms are all different, literally, for each agency. So, what took place is we were dealing with a number of agencies who had differing standards and conducts. Oregon, because of its size, we found out was much, much more difficult to monitor and supervise than what we had ever experienced in the past.

We did start out in Oregon with several programs for providers who had their licenses revoked. We had to jump in without much notice and inherit certain programs, nonlicensed, obviously not performing up to standards which always makes it extremely difficult to start business under that format.

We set up various policies and procedures that were generally acceptable and successful in all other States, and what we basically determined is that those policies were not being followed through by the management staff that we had put into place in Oregon, and, as a result of that, we have had to terminate a significant number of direct care, to home manager, to mid-management, to executive director positions.

Chairman WYDEN. Before you hire workers at ASI, do you do background checks?

Mr. D'LUGE. Yes; we do.

Chairman WYDEN. Of the individual you are looking to hire?

Mr. D'LUGE. Part of our policy.

Chairman WYDEN. What does your typical background check consist of?

Mr. D'LUGE. Well, in terms of specifics, there is a complete policy manual. There is a criminal investigation, background, as I think somebody testified earlier to. Sometimes, we do not have the luxury of getting that report back because that report sometimes may take a month or longer. Frankly, one of the most difficult problems that we faced in Oregon is the inability to attract staff members at the levels in which the State funds those direct care positions.

In terms of the budget process those are broken down into certain categories. There is x amount of dollars allocated for direct care. Compensation, and we have done our best to offer what we can for those positions and the fringe benefits that we can afford under those specific categories. But the fact of that matter is that we have had a very difficult time being able to even fill positions which has put us in situations where there have been employees who have worked more than one shift at a time. Sometimes, the people have not conducted themselves in accordance with the policies.

But there is a criminal investigation check. If, in fact, that comes back indicating any type of prior, criminal activity, then that person's employment is conditioned upon that inspection being positive. In addition to that we do three references. We check for high school, graduation requirements. If there is any type of additional degrees, we check that background. Generally, three references and past employer practices.

Chairman WYDEN. My understanding is that you will hire somebody even if there are grounds to believe they may have been involved in criminal activity. Is this correct?

Mr. D'LUGE. No; what I had testified to is that there are occasions in which we will hire people before we get the actual report back, and then when we receive any information that indicates that there is any type of criminal background, obviously then we would terminate them immediately.

Chairman WYDEN. You have done that?

Mr. D'LUGE. Oh, yes.

Chairman WYDEN. I would be interested in the subcommittee being furnished the information.

Mr. D'LUGE. That is not a problem. Now, I am not positive this is in Oregon only, but I know Michigan, as an example, does have an appeal process that we are by State regulations obligated to allow the employee an opportunity to seek approval directly from the State if there is any question in terms of that person's criminal background check.

Chairman WYDEN. I think all of you have been very patient, and we appreciate it. We look forward to working with you in the days ahead. You have a big job. Clearly, with the trend toward deinstitutionalization, this problem will require some very creative and innovative work. I believe that we can enhance the standards while still keeping the regulatory gate open for people who can deliver good care. We will work with all of you. We appreciate your cooperation. We will excuse you at this time.

Chairman WYDEN. Our next panel will be Ms. Elizabeth Jones, National Association of Protection Advocacy Systems, Maryland

Disability Law Center, Baltimore, and Mr. Jay Klein, the Institute on Disabilities, University of New Hampshire.

We welcome both of you. It is a practice of the subcommittee to swear all of the witnesses. Do either of you have any objection to being sworn as witnesses?

[No objection.]

Chairman WYDEN. Please rise and raise your right hand.

[Witnesses sworn.]

Chairman WYDEN. Ms. Jones, why don't you proceed. We must stick to the 5-minute limit. We will make your prepared remarks a part of the record. We appreciate your patience. We have been here a long time and you all have been very patient.

TESTIMONY OF ELIZABETH JONES, EXECUTIVE DIRECTOR, MARYLAND DISABILITY LAW CENTER, ON BEHALF OF NATIONAL ASSOCIATION OF PROTECTION AND ADVOCACY SYSTEMS

Ms. JONES. It has been a very interesting morning. Thank you for inviting us to speak.

Chairman WYDEN. Thank you.

Ms. JONES. I am Elizabeth Jones. I am the director of the Maryland Disability Law Center. We are a public interest law firm designated as the protection and advocacy system for the State of Maryland, and, as a board member, I am also representing NAPAS, the National Association of Protection and Advocacy Systems. NAPAS represents all of the 56 P&A's across the country and in the territories that are mandated under Federal law to investigate abuse and neglect in public and private facilities.

My written testimony summarizes a number of examples of how P&A's are involved across the country in investigating situations such as those discussed this morning. I won't go through each of those examples. I would rather summarize some of the general points we would like to make.

In my job at MDLC, we receive over 100 complaints a month from community and institutional programs alleging instances of abuse and neglect. Because resources are limited in all of the P&A's, we are forced to triage what we can investigate. But we have looked at, certainly, examples of sexual abuse, physical abuse, suspicious deaths, overmedication, and theft of client funds.

We see these allegations in both institutional and community programs, and the issues seem to transcend location. They seem to reflect rigid and restrictive policies and procedures and programs, a lack of consumer involvement and choice, a lack of individualized planning and programming, a lot of inadequate training, and in community programs inadequate wages for staff.

This morning you mentioned that direct care staff are paid at fast food wages. In Maryland, people receive \$4.50 an hour for working in community programs.

Because these are systemic problems transcending locations, we at MDLC, like our colleagues in our P&A's nationwide, have filed lawsuits against the State seeking to compel in both institutional and community programs licensing procedures, minimal training requirements, sanctions against violators, employee registries, and incentives to recognize positive practices.

I want to acknowledge that there are many excellent community programs and the characteristic we seem to see is that the residents of those programs are very much involved in the communities in which they live. Our challenge as the P&A is to monitor these programs, to investigate complaints or suspicions of abuse and neglect or poor practice, and to pursue administrative or legal remedies until the problems are resolved.

This morning you asked how can the Federal Government help. As you know, the Developmental Disabilities Act is up for reauthorization now, and the Subcommittee on Health and the Environment is now reviewing the suggested changes. The P&A's would be stronger if access was improved so that we can reach the people who cannot speak for themselves. The clients that we worry most about are not the people who can go to the phone and call us; they are the people who can't speak for themselves and who most likely will be ignored if someone doesn't go in and look to see what is happening to them.

Increased funding is absolutely imperative if the P&A's are to implement the mandate they have received from the Federal Government. We have, unfortunately, had to turn away hundreds and hundreds of requests to investigate abuse and neglect in community and institutional programs. There simply are not adequate resources to look at every instance that is brought to our attention.

Finally, the protection and advocacy systems need protection from retaliation when they do step in to investigate problems that have been brought to their attention. At the P&A in Maryland, we have been in constant trouble with the State as we seek to investigate systemic problems. Many times, programs like ours have their funding threatened because they have gone in and raised uncomfortable issues for States. Currently, we are being sued by a private facility to block our access to the facility, even though we know that children are being neglected there. So, there are many issues like this that come up in the course of trying to investigate abuse and neglect, and I think the situation will only be resolved if there is enhanced Federal funding and mandates so that the P&A's can go in and do what they are mandated to do.

We are deeply involved in these issues. We want to continue to be involved. We hope that you will see us as a resource and that you will look to help strengthen our ability to go in and pursue the remedies that are so necessary to solving these problems.

[Ms. Jones' statement, with attachments, may be found in the appendix.]

Chairman WYDEN. Well, Ms. Jones, that is an excellent point. Let me invite you and our other witnesses to give us suggestions for the reauthorization of the Developmental Disabilities Act. In my other life, I sit on Chairman Waxman's Subcommittee on Health and the Environment, which has jurisdiction over that statute. I am very glad that you touched on that.

Ms. JONES. Be very glad to.

Chairman WYDEN. Your bringing that up makes our hearing even more timely. I am glad that you did.

Mr. Klein, Welcome.

TESTIMONY OF JAY KLEIN, DIRECTOR, TRAINING AND DISSEMINATION, AND COORDINATOR, NEW HAMPSHIRE'S HOME OF YOUR OWN PROJECT, INSTITUTE ON DISABILITY, UNIVERSITY OF NEW HAMPSHIRE

Mr. KLEIN. Thank you. Over the last 20 years, I have been involved personally, working in institutions, working as a nursing home administrator, working and running group homes, and recently, from 1985-90, working for an agency in Colorado where I ran a series of group homes. During this time period, we closed those group homes and the 80 people who were living in those homes began living in their own homes, receiving the support they needed to live in their own homes.

In my written testimony, I talked about things that we have done in the past that haven't worked and things that many people have done in response to those things that still aren't working. Today, we have heard a lot about what isn't working, which I also highlight in my written testimony.

Instead, what I would like to do today is talk about where I think we need to go. First, I would like to submit something else to the written testimony which outlines some of the areas that I think we need to address. These areas are included in this paper on personal assistance services.

Chairman WYDEN. Without objection, we will enter it into the record at the conclusion of your testimony.

Mr. KLEIN. OK. Great. Many people today have addressed the idea that we need to look at individuals. If we truly look at the whole issue of individuals, then we really need to look at what the definition of individual is. An individual is one entity, one person. If we are going to truly concentrate on one person, then some of the issues that have been brought up today in relation to oversight and quality assurance become easier.

Rather than having States control people's homes, the people who are closest to individuals—parents, family members, and others—need to be involved in the planning and the control of what goes on for folks. We are going to be much more successful if we go back to the person and the people who are closest to that person, as opposed to depending on local governments, State governments, and Federal Governments to assure the quality for people.

Our belief is that everyone is ready to live in their own home. The issue is support. There is nothing magical about any building that we have seen anywhere in the country. What we know is that the magic is with the people who surround a person, and what we need to do is provide support to people so that they can be in their own homes.

We need to plan with other people. We need to plan with families. We need to make it happen.

The ownership and control needs to shift from agencies, States, or parents. Instead, it needs to be with the person who has the disabilities. He or she needs to own and control what is going on for themselves.

We need to focus on what people can do instead of focusing on what people can't do. We need to have and help people learn things

that make sense to them, and we need to truly do individualized planning.

I brought a few slides that will elaborate on my points. Through telling stories of a few people, I think you will better understand what I am talking about.

I need to have that turned on, and I need to have the clicker.
[Pause.]

Mr. KLEIN. OK. I am going to go through these slides quickly because of time.

This is an institution in Denver, Colorado. The people I am going to talk about slept in bedrooms like this, used bathrooms like this, and ate in dining rooms like this. Yes; we have reduced the large State institutions in this country, but there are still 84,000 people in these prisons.

This person's name is Sharon. Sharon came from an institution. When Sharon came from the institution she was on 250 milligrams of mellaril, was tearing hair out of her head, digging holes into her arms, slapping herself, screaming, and talking continuously. We could have called in the behavioral SWAT team to make it work for Sharon. We could have created all sorts of programming, all sorts of regulations, and all sorts of standards to make it work, but what we did instead was help her live in her own home, and we listened to what she was saying.

Here is Sharon 3 years later. Without going into the whole story, Sharon is not on medication here except seizure medication. This was not easy for Sharon or for the people who supported Sharon, but we stayed with Sharon, we walked with Sharon, we listened to Sharon, in order to make it happen for her.

Sharon really liked to touch people, but wasn't allowed to touch people in many of the facilities she was in. Here she is learning how to become a massage therapist. Sharon also doesn't see. Now she touches people a lot.

When she was at the institution, this was her roommate, Karren. Karren also lived in the institution on a behavioral unit. She had severe cerebral palsy, mental retardation, quadriplegia, and would cry all the time. Here is Karren riding in a hot air balloon in Greeley, Colorado.

Karren now reads books to kids. Part of it is really understanding what people can do. Karren doesn't read. So, how does Karren read books to kids? She goes to the library and picks out the books. She makes up the stories, because the kids don't read either, and the kids don't mind very much. These kids got together, you can't really see it, but there are little buttons that they have on them. They went around knocking on people's doors to collect money so that their teacher could have a ramp built to get into the playground, and they raised enough money to do that.

Jeannie also lived in an institution at the same time. She was in the institution for 23 years. Jeannie doesn't talk. Jeannie doesn't use her arms. Jeannie doesn't use her legs. But Jeannie spelled out to us when she was in the institution the first time we met her, "Get me the hell out of here."

We really can't tell what Jeannie's disability is here. Jeannie is in Berkeley, California, preparing for a speech before 100 people.

This was Jeannie this summer. Next summer she is planning on getting married.

This person's name is Mark. That refrigerator is not small; Mark is big. Mark used to use his bigness to hurt other people. Mark has something that we call autism, and Mark needed somebody to be with him. When Mark goes places now, there is somebody who kind of puts their hand on his shoulder and tells him that things are going to be OK. Mark hasn't had any problems in 5 years, although Mark was in the newspaper recently because he donated 8 gallons of blood over the last 10 years in his community.

This person's name is Norman. He is from New Hampshire. He lived in the institution for 28 years. Norman, now lives in his own apartment, and he has a roommate who lives with him. In fact, last week, Norman and his roommate came and spoke in my class that I teach at the university.

Norman goes to Red Sox games. Norman has people from all over the country who came to visit—these people are from Georgia—people come to visit him to find out how he is doing it, what it is about, and how he is living.

Here are some people from Washington, DC, from the Administration on Developmental Disabilities, who came to visit him.

A couple more people real quick. This is Roger. Roger does not see. Roger has severe, or profound mental retardation. Roger would bite people a lot.

Roger is living in his own home now. We went to the local church and said, Roger would like to be a member of your church, the Episcopal church, and so they introduced us to this woman who has her arm on Roger's shoulder, Deirdre, and Deirdre said, "I'll take care of it," and so Roger, who doesn't talk now, sings in the choir, because Deirdre sings in the choir.

Here are people from Roger's community in his church, they are called the Hospitality Committee, which welcomed Roger into the church.

This last set is just 2 pictures. They give the message of my written and oral testimony. If we envision and look at Denise like this, in this particular chair she looks sick; she looks like she needs a nursing home; she looks like she needs some sort of care; she looks like she needs a lot of standards to make sure that she will be healthy and that her well-being will be taken care of.

But, if we surround her with people who care about her, those people will help us figure it out, and they will say that Denise should look like this, because this is Denise 24 hours later. All that changed is her clothes, her chair, and now she is in her own home.

This is what I have to present. The only additional thing that I would like to mention is that I would be happy to work with you in any capacity that you would like in the future to provide you with any information on any of the options that I have talked about today.

Thanks for having me speak.

[Mr. Klein's statement and photographs from the slides may be found in the appendix.]

Chairman WYDEN. Mr. Klein, what a great way to end the hearing. As you know, we can talk all about the rules, the shell corporations, unannounced inspections, and minimum standards for

quality assurance, but it really comes down to those pictures. It is really exciting to be able to finish this hearing with a sense of what is possible. That is why you all do your work and that is why people are involved in public service as well.

Because that is such a fitting way to end, I will ask staff on both sides of the aisles, both the majority and the minority, to submit some written questions to both of you. I know that we are very interested in following up on some of the problems outlined by Mr. Medonis. I think you all were here for Mr. Medonis' testimony. I found that very, very troubling testimony. This is not a simple matter of a difference of opinion. Mr. Medonis is talking about systemic blind spots, systemic kind of areas that need to be strengthened.

We do, as you said, Ms. Jones, have the vehicle. As we push for accountability in the professional health care area, we can push for some accountability in the Congress to be responsive to the things you are talking about.

Unless you all have anything further, we will end this hearing on the very promising pictures that Mr. Klein showed us. Do you all have anything else you would like to add?

Ms. JONES. Thank you very much.

Chairman WYDEN. We have much hard work to do. I want to recognize the minority now. We will hold the record open for statements from our colleagues on both sides of the aisle. We will have some questions for you, Ms. Jones, and you, Mr. Klein, that we will submit in writing. We invite the minority to do that as well. Would minority counsel like to add anything further?

Mr. LEHMAN. That is fine. We may add some statements and some questions for you all. We appreciate your testimony.

Chairman WYDEN. Very good. We thank you both for your patience.

Chairman WYDEN. The subcommittee is adjourned.

[Whereupon, at 1:30 p.m., the committee was adjourned, to reconvene subject to the call of the chair.]

APPENDIX

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103d Congress

United States House of Representatives
Committee on Small Business
Subcommittee on Regulation,
Business Opportunities, and Technology
3-363 Rayburn House Office Building
Washington, DC 20515-6318
OPENING STATEMENT
REP. RON WYDEN

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RESIDENTIAL PROGRAMS FOR THE MENTALLY RETARDED:
POOR QUALITY CARE, WASTE AND THEFT OF MILLIONS IN PUBLIC
REIMBURSEMENT; DANGEROUSLY INADEQUATE OVERSIGHT BY
FEDERAL, STATE AND LOCAL AUTHORITIES

BEFORE THE SUBCOMMITTEE ON REGULATION, BUSINESS
OPPORTUNITIES & TECHNOLOGY

March 29, 1993

Today, the subcommittee continues its examination of new and emerging healthcare services dominated by small businesses. The question before us at today's hearing is whether government regulation of small group homes for the mentally retarded and developmentally disabled -- an \$11 billion-per-year business which has developed largely within just the last decade -- protects clients against dangerous or abusive treatment, and protects the taxpayer against fraudulent or wasteful spending of billions in public reimbursement dollars.

This subcommittee has found substantial evidence that patients and taxpayers are frequently being exploited by small businesses that run homes for the mentally retarded and the developmentally disabled. While most providers appear to be conscientious and professional guardians of some of the nation's most vulnerable citizens, many others may be doing a poor or even criminal job of preserving a huge public trust.

A key measure of society is how it treats its less fortunate. For some of the 300,000 Americans who are living in 40,000 of these homes -- many of them for-profit facilities receiving a ton of public reimbursement -- our society has failed its obligation.

The subcommittee found evidence of retarded or severely disabled persons being raped, beaten and even killed in these facilities. Medicines were mis-administered with sometimes disastrous results. The clients had their possessions were stolen, and they were shut-off from family and friends. State public officials charged with their oversight had little or no knowledge of conditions within their homes ... or at best, found out only after terrible events had occurred.

The incidents detailed in the subcommittee memorandum deaden the soul as well as chill the blood. Our country must do better.

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The subcommittee found evidence that through complex financial organizations, managers of "non-profit" homes make a cash-killing by developing for-profit companies to service these "shell" facilities through over-priced, sweetheart deals.

The stakes are not penny-ante. For example, in 1988 providers in this field secured \$4 billion from Medicaid, \$3.6 billion from Title XIX funds under the Social Security Act, and an additional \$2.1 billion from federal Supplementary Security Insurance.

In state after state, small providers operating hundreds of homes and programs in geographically dispersed locations have successfully evaded quality assurance oversight. The system that is supposed to protect the developmentally disabled is swamped. Caseworkers responsible for oversight of these programs are critically over-burdened. Some may have over a hundred cases, each.

Too often, providers are left to operate on a sort of "honor" system. State authorities believe that conditions are up to standard primarily because they've been told so by the care-giving companies.

Regarding staffing at facilities, the subcommittee found a pattern of inadequate pay and under training. One academic expert who has examined the impact of staff pay and benefits at these facilities noted that providers too often pay wages competitive with fast-food restaurants. As a result, the consistency of care and training is always an open question. The pay and benefits problem mirrors a similar issue revealed last year in the subcommittee's investigation of quality-of-care in rehabilitation of the traumatically brain-injured.

There appear to be conflicting and confusing jurisdictional problems between federal and state authorities. The provider community includes several multi-state companies each featuring scores of facilities. Under federal policy, the individual states have most of the responsibility for tracking the financial dealings of these large providers -- an audit job simply beyond the ability of most state programs.

Federal oversight and accountability over these homes needs to be strengthened. Currently, once a state obtains federal Medicaid dollars to provide care for the mentally retarded and developmentally disabled, the job of assuring quality, the adequacy of auditing standards and the screening of home operators is left to state regulators, whose performance is spotty at best.

Page Three

Again, witnesses today will testify that there are many good providers in this field. Government has encouraged their development as an antidote to the poor conditions and oppressive quality of too many large state hospitals... once the only means of serving this population. But these witnesses will add that the wide-open regulatory nature of the environment, coupled with a steady flow of poorly monitored public spending, has created substandard and even dangerous care for too many clients.

In the last decade, thousands of developmentally disabled citizens left the large, "snake pit" institutions for the small facilities which promised to house, train and employ them. The Chair is concerned that in too many cases the worst abuses of the large institutions are being recreated in miniature.

The Chair believes that there is a great need for improved state advocacy programs. Today, advocates often can only address the most egregious abuses while far more stealthy providers -- doing only the bare minimum necessary to meet state paperwork requirements -- get by, and their clients languish amid depravation and neglect.

The Chair believes that it is possible to have enhanced standards of care for these vulnerable Americans, while still keeping the regulatory gate open for the development of innovative programs and good-quality, new providers.

Indeed, in some states a principal problem is too few providers and no competition. The subcommittee has been told that states may be stuck as a poor operator, simply because there's no other provider ready, willing and able to step into the breach.

Today, we will hear some unacceptable alternatives to real reform in this field:

- * Al Medonis, of the Massachusetts Auditor's Office, will tell how the state may have lost as much as \$50 Million in the last four years to dubious businessmen who set-up shell corporations to build and operate small group homes, about questionable lease-backs and profiteering at the expense of the clients. If it is happening in Massachusetts on this scale, it is happening across the country.
- * Other witnesses, family members and a former employee of a group home, will tell even more disturbing tales of clients raped in homes operated for years under the noses of state authorities. We will hear of home operators who failed to notify guardians when clients wandered off for days at a time, and who kept abusive employees on the payroll long after problems arose.

Page Four

We will hear descriptions of under-paid and under-trained employees, and of states that prop-up poor providers because they have nowhere else to place clients.

As we debate the cost of healthcare in this country, as we think about how we are going to pay for the long-term needs of the developmentally disabled, we must consider how to build better quality assurance systems.

We have a social contract with these people. We have promised to take care of them. That includes allowing them to live their lives in the least restrictive way possible, and in places which are safe and clean.

States must develop an approved system of quality assurance that meets standards sufficient to protect the vulnerable. The chair believes that the federal government should work with the states so that each state has a quality assurance program designed and in place to qualify for a Medicaid waiver.

A national information exchange on quality assurance and enhancement efforts would also be in the public interest. States and providers need quick and reliable access to models that work. States also need to know quickly about the track record of providers and their personnel in order to weed out crooks and criminals.

States should establish minimal training requirements for facility employees. Again, authorities need flexibility in designing training programs. But in state after state, abusive treatment can be traced to poorly trained and managed staff.

Finally, we must discourage states from over-reliance on any single provider and to beef up financial auditing of provider. Abusive providers, providers with a history of violations, should be run out of the business quickly. There also needs to be improved efforts by states to know where the money goes and how it is spent. Only in that way can we assure that the millions now lining the pockets of bad operators will be used for enhancing the lives of the mentally retarded and developmentally disabled.

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103d Congress

United States House of Representatives
Committee on Small Business

Subcommittee on Regulation,
Business Opportunities, and Technology

363 Rappah House Office Building
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March 22, 1993

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TO: Ron Wyden, Chairman, Subcommittee on Regulation, Business
Opportunities, and Technology

FROM: Subcommittee Staff

SUBJECT: Residential Programs for the Mentally Retarded:

Out of Sight, Out of Mind?

Poor Quality Care, Waste and Theft of Millions in Public
Reimbursement; Dangerously Inadequate Oversight by
Federal, State and Local Authorities

INTRODUCTION

In the last session of Congress, the subcommittee examined a number of emerging small business trends in the healthcare industry. Increasing healthcare costs as well as changes in practice standards and standards for acceptable providers have given birth to a myriad of non-traditional healthcare business opportunities. Among those examined by the subcommittee has been the emerging field of ambulatory surgical practices, head-injury rehabilitation facilities and clinics providing alternative and non-traditional health treatments.

An area of increasing healthcare quality and cost-containment concern, however, is the long-term treatment of the mentally retarded and developmentally disabled. Increasingly, millions of Americans with these life-long handicaps are at risk from poor quality care, questionable and even criminal management practices by service providers, and lackluster monitoring by public health and welfare agencies.

This is a service sector dominated by small business providers, and which generates in excess of \$11 billion per year in revenues, much of it reimbursed through state and federal health insurance programs.

Subcommittee staff has conducted a year-long investigation of providers of assisted and independent living arrangements for the mentally retarded. The result indicates that growth in this industry has out-stripped the ability of many state agencies to adequately oversee conditions in these facilities.

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A disturbing pattern of abuse, neglect and fiscal mismanagement has emerged.

Central to this issue is how to best protect the health and welfare of citizens who are in the public trust -- in other words, persons of diminished intellectual capacity who are unable to effectively protect themselves when selecting or receiving healthcare services.

There are over seven million retarded persons currently living in the U.S. Estimates of the 1988 average daily population of Mentally Retarded/Developmentally Disabled (MR/DD) individuals living in residential facilities, foster homes, psychiatric facilities and nursing and personal care homes nationwide range from 268,771 to approximately 330,000. Because the mentally retarded often cannot speak in their own interest, there is a compelling need for government oversight.

Federal Medicaid funding for just one sub-set of the industry -- mid-sized, intermediate care facilities, rose from \$573 million in 1977, to \$2.4 billion in 1988.

Increasingly, however, privately operated homes for the mentally retarded and developmentally disabled fall through the regulatory cracks.

Annually, the federal government spends billions of dollars on care for the mentally retarded and developmentally disabled, mostly through small business operators in the field. Of the \$11.7 billion generated in residential treatment of the mentally and developmentally disabled in 1988, approximately \$4 billion came from Medicaid, \$3.6 billion came from the federal Title XIX program, and \$2.1 billion came from Supplementary Security Insurance.

WHAT STAFF HAS FOUND:

- * Some providers operating networks of homes continually violate Medicaid regulations and public health codes. Problems include: poorly trained and abusive staff, inadequate oversight of medication, poor food, dangerous sanitary conditions, lax accounting and record keeping.
- * Both for-profit and non-profit providers who have incestuous relationships with subsidiary, for-profit corporations to lease-back housing, provide employment and physical therapies, and consulting services. These relationships appear to be designed to maximize profitability of these ventures for managers, yet they clearly constitute conflicts-of-interest and, in some cases, violations of law.

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For example, the State of Massachusetts estimates that abuses in that state could be as high as \$50 Million over the last four years.

- * Homes and providers across the country have been cited for pages of health and safety code violations. Yet some states have not closed down a single home for poor conditions or failures to provide contracted services. For example, a Michigan operator obtained four licenses to run small group living facilities and then pooled his clients into a single, more profitable facility that the state was finally forced to close because of adverse health conditions. This closure, however, occurred only after years of reported patient and financial abuse.
- * Regulators are unsure of which agency wields ultimate authority in a state for MR/DD programming, and there is significant confusion regarding jurisdiction. This leads to poor oversight, and the continuation of unhealthy, financially abusive and even dangerous conditions at some homes dependent on significant public support. Federal auditors, for example, often have little knowledge of how monies flow through state agencies to intended beneficiaries.
- * Employees at small, community based facilities are often under-trained, poorly paid and inadequately screened. As one New York state official put it: "some consumers leave institutional programs where staff have received 100 hours of training and move to homes where staff do not even know first aid."
- * Home residents have been the victims of physical and emotional abuse and neglect. Marlene Carson, an Oregon mother, complained to the subcommittee that: "they don't tell guardians anything." Her son -- a resident of a supervised small group living apartment complex -- had wandered away from the facility, sometimes missing for days at a time, before she was notified that he was gone.

According to a recent Miami Herald article on problems in MR/DD programming: "For the lucky, the new 'system' works. They have found or been placed in group homes that work as homes, that offer clean shelter and caring hands. For the others, though, the snake pit has only broken into nests that are out of sight and out of mind."

The court-ordered rush during the last ten years to move mentally retarded and developmentally disabled persons out of oppressive, large, state-run facilities has resulted in the creation of myriad of small, privately operated "homes." These small business ventures easily slip through poor or non-existent federal, state and local quality assurance efforts.

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The subcommittee has scheduled a hearing to examine these issues, time and place as follows:

Time: 9:30 a.m.

Date: Monday, March 29, 1993

Place: Room 2359 Rayburn House Office Building
Washington, D.C.

I. PATTERNS OF ABUSE

In state after state, subcommittee staff learned of charges of physical abuse, neglect, and potential profiteering.

Typical examples of abuse, neglect and profiteering include:

CONNECTICUT:

Connecticut Community Services (CCS), a West Hartford, nonprofit corporation, received \$3.4 million from the state last year to operate nine group homes for retarded adults. State auditors found that CCS owes the state \$425,000 for improper or unsupported billings over a period of three years. In addition, the company owes the state another \$526,000 for its failure to return double payments made by state agencies over the past few years.

The founders and owners of Charter Oak, another group home program, opened homes in Connecticut after having just left a Salem, N.H. group home in bankruptcy. In took less than two years for their Connecticut homes to reach the same predicament. Inspection reports of homes cited low food supplies, staff shortages, lack of programs for residents, filthy clothing and evidence of neglect, such as men who had gone unshaven and women who had developed yeast infections. Inspections also found that untrained staff members were giving prescription medication to residents. Professional medical services were considered inadequate and blamed for a 30-year-old retarded man's accidental overdose of lithium and other behavior-modifying medications in January, 1989. The man was hospitalized. The company owes the IRS more than \$100,000 and owes hundreds of thousands more to a firm that renovates houses and rents them to group-home operators.

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MASSACHUSETTS:

The Center for Humanistic Change in Springfield directed \$1 million of its state contract money for twenty group homes to other businesses Center owners controlled. In several cases the Center, which is private and nonprofit, paid inflated prices to rent buildings owned by the Center's three founders, or paid administrative service fees to a company also owned by the founders. On disclosure forms required to be filed with the state, the Center apparently violated state law by concealing the fact that its administrator also owned a realty trust and rental company from which the Center subcontracted services. State officials terminated the Center's \$5 million per year contract.

Massachusetts Deputy Auditor Robert Powliatis told subcommittee staff that fraud and misappropriation of state funds directed to small group home operations in the state "conservatively" run as high as \$10 million per year and may be as much as \$50 million over the last four years.

MICHIGAN:

In Imlay City, Brenda Berger, a 30-year-old mentally ill woman died after the state Department of Social Services had warned her group home for months that it was improperly administering Berger's drugs. Berger's death also occurred two months after the department notified the home its license was being revoked for serious care violations. Forensic experts were unable to identify Berger's cause of death.

NEW YORK:

The Hi-Li Manor Home was cited during 1990 as one of the 14 worst adult group homes in the state by the State Commission on Quality of Care for the Mentally Disabled. Instead of upgrading care, the managers funneled \$4 million of public funds, including Medicaid dollars, into investments, interest-free loans to themselves, excessive salaries for themselves and relatives, car purchases, tuition payments for relatives and insurance payments on homes, and jewelry and furs, according to the state oversight agency.

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IV. INADEQUATE LIVING CONDITIONS AND ABUSE OF RESIDENTS

Federal law requires the placement of retarded people in the least restrictive environment that is consistent with their physical and mental needs. The Health Care Financing Administration has enforcement authority over homes receiving Medicaid. Nevertheless, sporadic incidents of inhumane treatment are a recurrent problem. For example:

- Five homes in Bakersfield and Lamont, California, were closed in April 1992 for alleged neglect and endangerment of adult, mentally retarded clients. One staff member served six months in jail for sexual battery. Another staff member is accused of using restraint methods so violent that he broke a client's arm. Even the home proprietor has been accused of punching a client in the face.
- In Michigan, state mental health officials investigated the case of a group home client who almost died as a result of a drug overdose. State reports of the investigation reveal that cockroaches were crawling across the pages of the medical log reviewed by state investigators and that resident medicine was generally kept in unmarked brown paper bags. The home had been cited repeatedly since 1985 for violations, yet remained in operation.

Although many, if not most homes for the mentally retarded and developmentally disabled are clean, safe and well-managed facilities, others are cause for grave concern. In the words of Jay Klein of the Institute for Disabilities at the University of New Hampshire:

"The system we've set-up is crazy ... what we are building is disability ghettos."

V. DENIALS, INTIMIDATION AND COVER-UPS

Parents and guardians complain that they are routinely denied access to their children's medical records and other critical information. No legitimate business reasons are offered for such secrecy.

- At one residence, staff members were required to sign a form that explicitly threatened termination for any employee who spoke out publicly about conditions in the home.

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Home operators have also sought to intimidate the retarded residents in their care:

- At a home in Michigan, residents were beaten by staff for talking to reporters and government investigators. The retarded residents had complained about being forced into sexual relations with the home manager.

VI. INADEQUATE QUALITY ASSURANCE AND FACILITY OVERSIGHT

Subcommittee staff have identified a number of troubling loopholes in state and federal regulations pertaining to quality care for the mentally retarded and developmentally disabled, and numerous flaws in government enforcement measures. Often, facility operators are inordinately preoccupied with passing irregular and periodic inspections rather than striving for a high level of care. Although indications are that most homes provide quality care in an efficient, caring and lawful manner, too many providers have routinely taken advantage of complex rules and regulations for personal gain.

Specific deficiencies in the way the system is organized and in the way it operates almost invite companies to thwart the rules:

Deficiency #1: Many states perform inspections infrequently and usually give prior notice.

Not surprisingly, homes pass inspection by making special preparations before scheduled on-site visits. But performance and a home's appearance during an inspection may indicate little about staff conduct during the rest of the year.

The system, in short, as Jay Klein, Professor at the University of New Hampshire and expert on MR/DD housing, told the subcommittee, is one of "'Dump and Hope'... dump the people in a home and hope nothing bad happens".

Deficiency #2: Staffing levels on inspection and auditing teams are too low to perform comprehensive and frequent examinations.

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Unscrupulous providers recognize that only the most blatant abusers will be targeted by state agencies. Merely by keeping a low profile, home operators can avoid careful scrutiny. Further, in many states case managers -- the first line of protection -- are over-burdened with too many cases and unable to effectively oversee the services provided to individual MR/DD clients.

As was reported in a 1991 study by the University of Minnesota's Center for Residential and Community Services, in some states case worker contact with clients was "so infrequent as to suggest almost exclusive dependency for service quality monitoring on provider self-reporting of recipient needs and program deficiencies, or on the complaints of recipients, family members or interested others."

University of Minnesota Professor K. Charlie Lakin told the subcommittee that when it comes to quality assurance, inspectors and case workers may "understand their checklists well, but understand the quality of life for clients hardly at all."

Deficiency #3: Agency oversight teams frequently judge contractors solely on their record keeping ability.

Home operators may slavishly follow paperwork requirements, yet provide only the bare minimum of required care and services. Innovations -- developing programs outside the straight and narrow -- is discouraged. Furthermore, concerned employees and parents charge that records are easily altered and manipulated to satisfy regulatory requirements.

Federal support for MR/DD programming comes through Medicaid funding overseen by the Health Care Financing Administration (HCFA). However, because states operate MR/DD programming under a Medicaid waiver, HCFA's review procedures consist solely of auditing financial reports, examining receipts, and evaluating processing and compiling procedures.

In the best of circumstances, the Medicaid waiver enables states to tailor residential programming to individual needs and state conditions. In the worst cases, federal dollars wind-up subsidizing questionable programs and providers with little or no direct oversight.

Deficiency #4: Certification requirements, background checks and investigation of qualifications are often procedural and cursory.

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In many states, virtually anyone can open a home. Little regard is given to an owner's track record in other states. Owners need not have any experience with the special needs of the mentally retarded community.

Deficiency #5: Procedures for revocation of a license are not credible.

Providers operating multiple homes have tremendous clout in many states. Usually, if a home fails the residents have nowhere else to live. States cannot credibly threaten to shut down a home unless appropriate alternative living arrangements exist.

Nancy Rosenau, an official at the Macomb/Oakland Regional Center outside Detroit, Michigan, explained the danger: "The key is to not have any one provider larger than we can put out of business -- we don't want to be at their mercy".

Competition among service providers -- a key selling point for privatization of residential services -- gets mere lip service in many areas. States usually roll-over expired contracts, rather than opening up the process to competitive bidding. State reluctance to move against questionable providers was highlighted in the University of Minnesota study which found that about half the states responding to its survey reported "rarely or never penalizing providers for deficiencies noted in the quality of their services..."

VII. WASTE, FRAUD AND ABUSE IS GROWING

Predictably, some unscrupulous companies have taken advantage of complex regulations and oversight deficiencies. Some representative examples:

- A group of businessmen in Massachusetts illegally sold group homes to a business they owned, at inflated prices. They also hid doing business with a related party, contrary to Massachusetts law. They pleaded guilty to cheating the state of \$500,000, which paid for a Florida condominium.
- Connecticut paid out \$230 million for care for the retarded without auditing a single operator. When the state finally conducted a limited review of two providers, the state found that one provider, Connecticut Community Services, Inc. (CCS) spent \$425,000 for improper or unsupported billings over a period of three years.

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In addition, the investigation discovered that CCS owes the state another \$526,000 for its failure to return double payments made by state agencies over the past few years. Forced by court order to remove individuals from state-operated hospitals, Connecticut rapidly contracted with almost any business willing to provide immediate services.

State officials concede that they made mistakes, but they contend that most of the expenditures were technically legal. Some home operators realized that they could buy "gold-plated" structures from related parties -- really from themselves -- and charge the state exorbitant prices. The state has since tightened its regulations, but the damage has been done.

VIII. UNDER-TRAINED AND POORLY COMPENSATED STAFF

Virtually all homes in the community employ personnel who have little experience working with mentally retarded or developmentally disabled individuals. To satisfy training requirements, many providers give employees only the most basic healthcare training -- for example, a two-week crash courses in first aid may be the only specialized training that an employee will have.

Poor staff compensation is virtually universal for those paid to care for our nation's most vulnerable citizens. The 1992 mean starting wage for direct care workers in private community facilities nationwide was approximately three percent above the poverty level for a family of three. More than 50 percent of private community facilities report starting wages for full-time workers that are below the poverty level for a family of three.

- * Seven state-specific studies conducted between 1986 and 1989 indicated that on average the wages paid by community facilities were 54 percent less than institutional wages. Average institutional wages are \$8.72 per hour, while private community facility wages average only \$5.97 per hour.
- * Starting wages in private community facilities can be as low as \$5.22 per hour.

Across the board, wages have failed to keep pace with inflation over the past decade.

Community facilities also offer substantially fewer employee benefits than their institutional counterparts. For example:

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- * A significantly lower percentage of community facility employers offered dental, retirement, child care, and tuition assistance benefits than institutional employers in 1992.
- * A 1988 Maryland study found that institutional benefits averaged 40 percent of wages, while community facility benefits averaged only 16 percent of wages.

Not surprisingly, staff turnover is a major problem. Furthermore, experts link dissatisfaction over low wages with a tendency to abuse or neglect the clients. A 1980 survey of more than 2000 facilities found that the most frequent difficulty reported was recruitment, retention, and development of staff (85 percent of reporting facilities). Turnover was reported as an even more serious problem than obtaining adequate funding (65 percent).

Employee turnover was almost three times as much as institutional turnover in 1992 -- 70.7 percent annual turnover for private community facilities compared with 24.8 percent for institutions. In seven states, the turnover rate was over five times higher in private community facilities than in institutions. The turnover rate for community facilities increased by more than 25 percent over the past decade.

The national mean length of service for full-time staff in institutions was 50.3 months, compared to only 14.7 months in private community facilities. More than half (55.9 percent) of the direct care staff separating in private community facilities leaves before completing one year on the job compared to less than one third (30.7 percent) of the workers in institutions.

In sum, low wages and poor training have become the hallmark of many private facility staffs.

"They're hiring people off the street for \$5 or \$6 an hour to care for patients who have extremely complicated seizure disorders, feeding tubes, all kind of problems" Dr. Cindy Ochs of Livonia, who cares for mentally retarded residents at about 40 Metro Detroit homes told the Detroit Free Press in a 1992 article on problems with community living situations in Michigan.

When these factors combine, woefully inadequate care can result:

- Subcommittee staff talked with numerous current and former employees at care facilities who freely admitted unprofessional and potentially dangerous practices by their colleagues.

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For example, former employees of one facility reported that prescribed medications for residents are routinely discarded. Later, current employees reported that the medicine was administered.

- Many of the problems arising in these facilities do not surprise the experts who have assessed the relationship between salaries and benefits, and the quality of healthcare. According to Dr. Dale Mitchell, Professor of Public Health at the University of Illinois, that "the MR/DD community facilities compete with McDonald's in the labor market for employees."

IX. FEDERAL AND STATE FUNDING FOR HOUSING THE MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED

Annually, the federal and state governments spend billions of dollars in an intricate system of care for the mentally retarded. Total MR/DD spending, both federal and state, increased from \$3.5 billion in 1977 to \$11.7 billion in 1988, representing a 72 percent increase in real terms and a 234 percent increase in nominal terms. Spending for facilities with 15 or less residents increased from \$879 million in 1977 to \$5.6 billion in 1988, representing a 225 percent growth in real terms and a 541 percent growth in nominal terms.

It is difficult to generalize people's specific needs, because impairments range from very slight to profound. Many mentally retarded and developmentally disabled individuals are more than capable of living on their own, with little or no extraordinary guidance. Many others, though, have a mental capacity and physical debilities which demand supervision and a special level of care. A significant number of people require assistance in daily tasks of living, like bathing, dressing, and preparation of meals. More than anything else, most of these people need a caring environment of well-trained professionals.

The services that are provided to people with mental retardation or developmental disabilities are spread out among several programs. Initially, most lived in hospitals and other large institutions, often placed indiscriminately with the mentally ill. Following the Willowbrook scandal in the late 1960s, governments transferred many people to community placements. Many now live in intermediate care facilities for the mentally retarded, generally large centers with training facilities and physical and mental therapy. More and more, states are turning to home and community-based services, which usually group five or fewer residents into an apartment-like setting to reduce costs.

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Other individuals live in less formal settings; homes with family, nursing homes, or board-and-care facilities.

Over the past 15 years, the number of residents in small facilities increased significantly while the number of institutional residents substantially declined. In 1977, there were 40,424 MR/DDs in facilities with 15 or fewer residents. By 1982, this number increased to 63,703 MR/DDs. By 1988, there were 131,161 MR/DDs living in facilities with 15 or fewer residents. Meanwhile, there were 207,356 MR/DDs living in facilities with more than 15 residents in 1977. By 1982, this number declined to 179,986. By 1988, there were only 137,610 MR/DDs living in facilities with more than 15 residents. One impetus for the decrease in institutional residents is rising costs. Institutional average daily costs rose from \$89 per day per resident in 1977 (in 1988 adjusted dollars) to \$154 per day per resident in 1988. The average daily cost of care rose to \$196.33 per day in 1990. Current average institutional daily costs are estimated to be well over \$200 per day.

Between 1977 and 1988, mentally retarded or developmentally disabled persons in semi-individual/supplemented living programs increased from 1,993 to 17,646. MR/DDs in specialized MR/DD foster care increased from 15,435 to 23,568. MR/DDs in generic foster care decreased from 21,410 to 13,981. MR/DDs in nursing homes increased slightly from 42,242 to 45,843. Also, MR/DDs in state mental institutions decreased from 15,524 to 1,970.

Funding and responsibility for the housing of the mentally retarded population is diffused among several agencies at the federal, state, and county levels, and shared with numerous advocacy groups and private accreditation councils. Medicaid now covers individuals in intermediate care facilities, as well as those placed in the community. Home and community-based services, however, are administered almost entirely by the states, under a Medicaid waiver. Other funding comes from Supplemental Security Insurance (SSI), from food stamps, and from various state agencies.

This diffusion of financing sources contributes to the lack of oversight and quality. As a result, regulators often don't know who has the ultimate oversight authority, and federal auditors may have little knowledge of how monies flow through the states to the intended beneficiaries. According to state and federal sources, some residential directors may not even be aware that their funding comes from the federal government.

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As previously mentioned, total MR/DD spending, both federal and state, increased from \$3.5 billion in 1977 to \$11.7 billion in 1988, representing a 72 percent increase in real terms and a 234 percent increase in nominal terms. Total public funding for facilities with 15 or less residents was \$5.6 billion in 1988, \$1.4 billion coming from the federal government and \$4.2 billion from the states.

The Medicaid budget has increased from \$32.7 billion in 1989 to an estimated \$81.5 billion in 1993. The federal government funds between 50 percent and 78 percent of Medicaid costs. Approximately 10 percent of the states' tax revenues was consumed by Medicaid in 1990. One report estimated that approximately 1.2 million mentally retarded or developmentally disabled individuals received some type of Medicaid funded service in 1987. Another report estimated that nearly \$4 billion in federal Medicaid funding went to MR/DDs in 1988. Approximately 75 percent of federal Medicaid funds went to intermediate care facilities for the mentally retarded (ICF/MRs) with the remainder going to small residential facilities and community services for persons living with families.

** Total Title XIX expenditures for the mentally retarded or developmentally disabled increased from \$616 million in 1977 to \$3.6 billion in 1988.

** Title XIX Funding for large public ICF/MRs increased from \$573 million in 1977 to \$2.4 billion in 1988.

** Funding of large private ICF/MRs increased from \$33 million in 1977 to \$451 million in 1988.

** Funding for small private ICF/MRs increased from \$9 million in 1977 to \$443 million in 1988.

Federal Supplemental Security Insurance payments to the mentally retarded or developmentally disabled totaled \$2.1 billion in 1988, which represented 23 percent of total federal SSI payments to blind and disabled payments. There were approximately 720,816 MR/DD recipients of federal SSI funds. State SSI payments to MR/DD's totaled \$316 million in 1988, which represented 16 percent of total state SSI payments. There were approximately 239,077 MR/DD recipients of state SSI funds.

Compounding the fiscal quagmire, multi-state, multi-home chains have entered the marketplace. "Mom and pop" foster homes are being rapidly replaced by large corporations. The subcommittee has discovered that some ostensibly nonprofit organizations operate for-profit subsidiaries; the incestuous business relationship between for-profit and nonprofit entities suggests that Medicaid may be paying less for the direct care of the residents and more for organization, accounting, and executive salaries.

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The states claim, with considerable justification, that they lack the resources and authority to audit multi-state providers. State governments are primarily responsible for the care that is given within their borders. Even if every state carried out this duty to perfection, the labyrinthine organization of some of these corporations could escape effective audit.

Clearly, the federal government has a role to play in ensuring the financial propriety of companies that receive federal funds. But, according to officials in the Health Care Financing Administration, federal policy grants the states almost complete enforcement of Medicaid regulations regarding the mentally retarded and developmentally disabled. Even though many states acknowledge they lack the means to trace the background of prospective entrants into the field, HCFA gives the states little guidance.

X. STATES CAUGHT IN THE CROSSFIRE

The Medicaid waiver program assigns states the primary duty to police the system. Theoretically, the states have significant incentives to carry out this task. States are responsible for between 22 percent and 50 percent of program costs.

The facts, however, taint this scenario. When the states are confronted with aggressive, well-organized corporate octopi, they often lack the resources or will to conduct careful review. In Michigan, for example, the number of adult foster care homes grew by 37 percent in the last decade, yet no new inspectors were hired.

In an era of scarce resources, state Medicaid Fraud Control Units, training and auditing programs are tempting budget-cutting targets even though they save more money in the long run. Forty-one states have Medicaid fraud units established to investigate questionable activities. However, commitment to these efforts vary by state. Some states, like New York, have made a major commitment of staff and other resources, winning significant victories. Other states with small staffs appear to only be going through the motions. More importantly, as with all too many healthcare frauds, corporations and questionable providers can avoid scrutiny by crossing state lines.

Even within the states, a chaotic and fractured bureaucracy paralyzes effective state action. HCFA regulations dictate that federal monies flow through a single state agency. But in reality, the financial accountability may be broken up between several departments.

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HCFA officials complained to subcommittee staff that the maze of state agencies continually thwarts efforts to investigate payments made to homes for the mentally retarded.

Gerry Provencal, the Director of the Macomb/Oakland Center in Michigan, said:

"States that have poor community-based operations are often characterized by a maddening lack of clarity in their interagency division of responsibilities, beginning with, 'Who has ultimate statutory responsibility for the consumer's welfare?' to understanding which agency has the duty to ensure that the plumbing works, the staff are trained, and the provider is not an absentee.

"There is question to doubt responsibility, authority, and initiative."

RECOMMENDATIONS

Some parents, concerned by abuses within the developing care industry and a perceived lack of responsiveness on the part of state agencies, argue that a return to housing the most difficult mentally retarded or developmentally disabled clients in large, state institutions has merit. These critics argue that in the large institutions -- even at their worst -- services and programming are centralized and the size of the facility militates against the most overt forms of physical and emotional abuse. These parents and guardians argue that all too many states have used the closing of large state facilities to cut costs at the expense of care quality for a vulnerable client population.

However, small business entrepreneurs in many states have shown that these services can be provided effectively in much smaller facilities. Neglect and abuse cited as the cause in the closure of many large state operated facilities suggests that the real issue may be the ability of states to provide a wide variety of care and housing options rather than relying too heavily on one system or the other.

MR/DD populations are not monolithic, their service needs and abilities vary greatly, and the significant federal contribution to paying for MR/DD services should be used to leverage and enhance models and programs that work, and discourage waste, fraud and abuse in programs that fail.

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Authorities should require a standard for measuring real quality assurance rather than finance the exchange of one questionable system for another.

There are clearly several areas where federal policy and contributions to state MR/DD program funding could be used to promote system-wide improvements. Among these, staff recommend:

1. REQUIRE STATES TO HAVE AN APPROVED SYSTEM OF QUALITY ASSURANCE.

The federal government should set minimum national requirements for each state to construct and implement a aggressive quality assurance program for these small enterprises. The federal requirement should be flexible enough to recognize individual state conditions. As the University of Minnesota's Center for Residential and Community Services Institute concluded in its 1991 study of state efforts to affect quality assurance: "such an approach to standards would in no way diminish the efforts of those states that have already developed programs or quality assurance and enchantment. On the other hand such a requirement for state programs would serve as a significant catalyst ..."

2. ESTABLISH A NATIONAL INFORMATION EXCHANGE AND QUALITY ASSURANCE /ENHANCEMENT EFFORTS.

States and small business providers need quick and reliable access to models that work. A clearinghouse should be established to provide states with information about what works as well as a repository for information about the track records of providers and personnel.

3. REQUIRE STATES TO ESTABLISH MINIMUM EMPLOYEE TRAINING REQUIREMENTS.

In case after case of poor quality of care, or of abusive treatment examined by the subcommittee, providers employed under-trained staff. Indeed, training provided by providers was often chaotic and the bare minimum necessary under the contract to meet state requirements. Training and professionalism should be the hallmark of a provider program, not a minimum requirement for licensure. Here again, without specifically mandating the shape of a training program, the federal government should require that states establish base training requirements for service providers as a qualification for federal funding.

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4. CREATE INCENTIVES FOR IMPROVED EMPLOYEE PAY AND BENEFITS.

The individuals charged to assist and supervise our most vulnerable citizens require pay and benefits commensurate with the difficult tasks our society asks of them. So long as states contract with providers who choose to maximize profits by underpaying staff, it will be difficult to encourage well-trained and loyal employees critical to providing quality care to mentally retarded or developmentally disabled persons.

5. DISCOURAGE OVER-RELIANCE ON ANY SINGLE PROVIDER.

State and local MR/DD housing and support programs require options. Efforts to rehabilitate poor-quality providers all too often come at the expense of clients. MR/DD housing and service programs that put clients first have the ability to move quickly to replace poor providers. Federal funds should be used to encourage state to build a broad-base of residential and service options, as well as competing and alternative providers. The best situation -- and one that should be encouraged -- seems to be described by a system of competing, small businesses.

6. IMPROVE STATE FINANCIAL AUDITING OF PROVIDERS.

As was shown in Massachusetts, effective state auditing will minimize the opportunity for financial abuse. However, to be effective, an effort must be made to better audit how individual clients fare under provider care. HCFA should undertake a survey on appropriate accounting methods to develop a model audit program for states receiving Medicaid support.

The Miami Herald

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Group homes of horror

PERHAPS IT'S time to return to the "snake pits." Reopen the state hospitals that warehoused the ill and the disabled in filth. At least those "snake pits" were huge targets for reform. At least society could see there the fruits of its neglect.

Ah, but society closed those hospitals in the name of humanity. Or so it was said. States such as Florida adopted policies of community care for the ill, the disabled, and others unable to care for themselves. Let these people be cared for in small, home-like settings; let them live like the human beings that they are. A better policy, one that would save money, just incidentally.

For the lucky, the new "system" works. They have found or been placed in group homes that work as homes, that offer clean shelter and caring hands. For the others, though, the snake pit has only broken into nests that are out of sight, out of mind.

Yes, of course the state inspects these places. The results: An example is Broward County. There the state has 12 inspectors for more than 400 nursing homes and group homes. That thin line of defense is stretched further by a law full of loopholes.

One Broward group home that accepts AIDS patients has been criticized for poor

FLORIDA FAILS PATIENTS

conditions since December 1989. The state refused to renew its license in September 1990, but the home is appealing and the decision may take yet another four months. In the interim, it *continues to operate* under conditions that a visiting county commissioner called appalling.

Another home surrendered its license in 1989 after failing inspections. It would be a boarding home, one exempt from state hotel inspections because it had fewer than four bedrooms. The state then received complaints that the home still was taking patients, but the state made no inspections for more than two years.

This issue of inspections is not new. In 1988, the state labored hard and long to shut a Dania group home where one man's bed sores were so deep that he needed skin grafts. It was a scandal that should have prompted sweeping action. But it did not.

Rather, the law continues to favor the owners of bad homes, not the 60,000 helpless Floridians who must depend on luck for the conditions in which they live.

State cuts make monitoring homes more difficult

the job of protecting severely disabled persons being moved out of state institutions.

In the case, the supervisory agencies were often at odds with each other, rather than working in concert.

In addition, the state inspector is now expected to monitor 115 homes, plus an average as many as 35 complaints a year.

That means many homes go three years before being inspected.

Meanwhile, about 800 applications to open new homes are on hold, despite more than 100 requests for additional beds and waiting lists for homes.

At the state Department of Mental Health (DMH) is planning to open 200 new homes in the next five years.

The problems have been magnified by budget cuts and the speed-up in closing state hospitals.

They are closing these institutions and putting all those people into the community, but you have to give the community what it needs to get them adjusted," said the director of the state foster care group homes in Ballville and Romulus.

"You just can't throw them out with a few pennies and say OK, there you are," he said.

He said that if the state had more money to take proper care of these people, we need more training.

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JOE DOVER, CHAIRMAN

"You just can't throw them out with a few pennies and say OK, there you are. I get about \$18 a day for some residents," says Alan Pittman, who operates group homes in Ballville and Romulus.

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When Lloyd Sherrill tried to turn an abandoned orphanage in Lapeer County into a community for the disabled, he lost most of his life savings. When David DeLauter, a former mailman, took over the 40-acre wooded complex — which he renamed His Majesty's Christian Center — he turned it into a business that took in more than \$800,000 a year, housing the disabled.

DeLauter, a fundamentalist Christian, often told people he felt called to open the home near Otter Lake because God had helped ease the back pain that forced him to retire from his Genesee County postal job.

Now, the 53-year-old operator of the center faces possible life in prison on felony charges that he forced five mentally retarded women at the home to have sex with him.

State officials, who pulled the home's adult foster care licenses in April, continue to investigate reports from residents and workers that residents were abused, forced to work long hours at low pay, pressured to attend religious services and kept in unlicensed homes.

DeLauter, through his attorneys, repeatedly has denied the accusations. At a recent hearing where DeLauter was bound over for a July 15 trial, his lawyer argued that the alleged victims had faulty memories and had been coached.

DeLauter's wife, Marian, a 56-year-old nurse and co-owner of the facility, refuses to comment, as does DeLauter.

A slightly built mustachioed man who often wears a cross around his neck, DeLauter is described by those who know him as both a charmer and a bully.

"When he wants something, he grabs someone by the shirt collar and sticks his fist under their nose," said Sherrill. "He is very controlling, very stern. At one point, I told him, 'Arrogance is never flattering.'"

"From that point on he was better around me, but he was still King Kong when it came to everyone else."

"Dave is a smooth talker. He pulled the wool over the eyes of a lot of people," said Bob Gifford, former president of the Village of Otter Lake. "He was always wanting to buy this, buy that and never

had the money."

Through a complicated and costly web of government programs, investigators are struggling to unravel, DeLauter created a community of vulnerable people no one else wanted — despite state policies discouraging such so-called dumping grounds.

To give him more clout with area courts and convicts at the center, who were sent by the courts to His Majesty's for substance abuse treatment, DeLauter was made a "special deputy" by the Lapeer County sheriff.

To help feed residents and workers, residents and workers said, the home cashed the clients' food stamps.

To help pay workers at a parts-sorting factory and several other businesses, DeLauter got job-training funds.

DeLauter controlled every facet of life on "The Hill," as residents called His Majesty's, according to dozens of former residents and workers at the home, residents' guardians, neighbors and state and local officials interviewed by The Detroit News.

Other information was obtained from government documents — including a March report used by the Department of Social Services (DSS) to close down the home — as well as testimony given before an administrative law judge considering the home's fate, and in Lapeer County District Court.

The real names of residents who claim they were abused and their family members are not used in this article to protect their privacy.

DeLauter had little more than his dream when he approached Sherrill about the run-down complex of six 1920s-era buildings in 1985.

Because DeLauter was a Christian, Sherrill said, he gave him six months rent-free to get started.

"We lost almost our life savings on it," Sherrill said. "We couldn't get a license for over 12 residents. They told us they didn't want another Okedale (a Lapeer institution that housed 5,000 mentally retarded)."

"He (DeLauter) pulled it off. I've got to give him credit, because we sure couldn't."

Within six years, the DeLautes turned the former orphanage into an institution for more than 60 disabled people, drug addicts and convicts. As recently as January, the state Department of Social Services (DSS) expanded the home's licenses to house more people — making it the largest such complex in the state.

Bonnie's story

Minutes before their alarm was set to waken them for church services, Tom and Darlene were roused by the ring of their bedside phone.

It was 7 a.m. The caller, Marian DeLauter, only would tell they had to come to His Majesty's right away.

As they drove to the wooded complex their daughter Bonnie had called home for five years, the sun seemed bright for February. Bonnie is mildly mentally retarded, with an IQ of 71.

When they arrived, the DeLautes told them sheriff's deputies had been out the night before questioning residents about stories of sexual abuse being circulated by some "disgruntled" employees.

"He had us almost completely convinced these girls had made it up," Darlene said. "We loved and trusted them. We didn't want to believe it."

But one look at their daughter convinced Tom and Darlene there was more to it.

"She came out of the house and was like a ghost," Tom said. "She stood like a robot. Pale. Her lips were colorless."

DeLauter suggested Bonnie talk to her parents in his office, where most of the abuse allegedly occurred.

"While we were talking in his office, he interrupted us on the intercom," Tom said. "He could have been listening to the entire conversation."

Bonnie said DeLauter started forcing her to have sex with him to "relax her" about 18 months ago.

"I didn't know what he would do if I told," said Bonnie, 23. "I'm not sure if he would have hurt me or grounded me. He said we'd be in big trouble."

Earlier this month, Bonnie testified she was frightened of DeLauter, whom she once saw grab somebody by the throat.

So, Bonnie said, she went to DeLauter's office when he called.

In between, she cleaned house for the DeLautes and their friends, helped care for his mother-in-law, sorted parts at the factory and helped out at a bait shop and pizzeria owned by DeLauter and



DALEG. YOUNG/
The Detroit News

David DeLauter

Please see DeLauter, 4B

DeLauter: Allegations of abuse cloud future

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his friends.

"At one point, she had four or five jobs at once," Darlene said. "I figured out what they were doing. One time I brought her home for a visit and wanted her to stay longer and Marian (DeLauter) went through the roof. She said, 'She has commitments and has to clean houses.'"

Residents also were pressured to attend weekly religious services — something Bonnie's parents didn't mind. One of the reasons they had chosen the home and trusted the DeLauters was because they were Christians, Darlene said.

"Who," she asked, "would take that kind of advantage of a retarded person in the name of Our Lord?"

'Highly respected man'

In 1980, David DeLauter was unemployed and collecting disability payments of \$1,090 a month for a "permanent" back injury, according to records of his divorce that year.

The records show that, business in which DeLauter was in at the time, a mobile-home repair operation, recorded losses in 1979 and 1980.

"He was always a highly respected man in the community," said Jack Hamilton, 26, who has known DeLauter for 13 years in Flint and worked for his mobile-home firm.

Hamilton said he lost track of DeLauter until he had a drug problem and went to His Majesty's.

DeLauter has been married three times. The record of his divorce from his second wife, Marilyn P. Kutrich, reveals a lengthy custody battle.

Kutrich accused DeLauter of exposing their two young daughters to his relationship with an unnamed "girlfriend," harassing and threatening her and turning their daughters against her.

DeLauter, who had custody of the children from 1981 until 1984, accused Kutrich of abusing them and said she had "serious mental problems."

In 1984, DeLauter's youngest daughter, then 14, moved in with her mother. Kutrich claimed in court documents that the daughter threatened to run away if forced to continue attending a religious school whose teachers were pressuring her to return to her father.

Kutrich, a nurse at a Flint hospital and DeLauter's wife of 16 years, refused to be interviewed.

No records could be found about DeLauter's first marriage. In 1982, DeLauter wed another nurse, Marian Bennett.

Three years later, the couple formed His Majesty's Christian Center as a for-profit corporation.

"Here were two individuals that said they wanted to serve a higher cause, their deity, and they even named their facility in such a way," said Richard Berman, executive director of Lapeer County Community Mental Health, an agency that sent dozens of clients to His Majesty's.

"How could we doubt them?" Berman said. "We're talking about a married man. Everything we saw was very positive. I would take guests to the grounds, we thought it was a fine place."

Louise's story

Debbie and her husband were called by the DeLauters the same February day Darlene and Tom were summoned. The drive from their southwest Michigan home to His Majesty's took four hours.

"We had no idea what was going on," Debbie said.

They were anxious to talk to their daughter, Louise, but aides in the Bennett Building where she lived insisted that the intercom be disconnected first.

"They told us to take her home, that she was real scared," Debbie said.

Louise, 26, had been crying out for help in her own way.

The day before, she had called home to ask her mother for their new address to send a letter, and seemed upset. Debbie later found the letter — in which, she said, her daughter talked about being sexually abused — stuffed into a notebook among Louise's belongings.

The same day she wrote the letter, Louise told another resident "she was being touched by Dave in ways she didn't like."

During the next 24 hours, Louise told her story repeatedly, first to employees of the home, then to deputies and, finally, to her parents. Each time, the details were the same. Louise has a closed-head injury that left her able to recall only repetitive events.

Louise told her parents and the Lapeer court that in the evenings, often when his wife was out, DeLauter called her to his office over the intercom for "one-on-ones."

In his office, "he'd say, 'Please, just let me sit in the chair.' He'd say, 'No, sit on the couch,'" Debbie said.

Louise and her other residents of the home testified earlier this month that DeLauter would lock the door and screen the window of his office. He then would touch their breasts, unzip his pants and force them to perform oral sex.

In the testimony, Louise said the last time she was called to DeLauter's office he "touched me between my legs after pulling down her pants." Then, she testified, he pulled his own pants off.

"I tried to get away but he had hold of me," she testified.

Debbie asked Louise why she hadn't told her parents earlier.

"She said she didn't think it would ever happen again because she cried so hard the first time," Debbie said. "And when it did, she said she was too embarrassed."

(DeLauter) had an excuse that day for each one of those girls' stories," Debbie said. "I mean, come on. None of them could get from one day to the next without help and all of a sudden they're the writers of these great columns?"

In fact, Louise had kept a journal when she first arrived at the center, but when DeLauter found out about it, he took it away, investigators said.

'Above reproach'

In a 1988 letter recommending DeLauter be appointed a special deputy to oversee convicts, Genesee County Circuit Judge Valdemar

Washington described him as "struck with a sense of purpose to serve others. His behavior is impeccable and above reproach."

DeLauter asked for the deputy status to help handle convicts in the drug rehabilitation program, said his peer County Sheriff Ron Kalanquin. He also was granted a permit to carry a concealed weapon, Kalanquin said, because of "the large bank deposits he made."

Washington told Kalanquin in the letter that he knew DeLauter from earlier attempts to place a Genesee court defendant in His Majesty's unlicensed drug program.

Most family members of the residents, even those who said DeLauter abused them, had some praise for him.

Please see DeLauter, 5B

Tapping the government purse

A number of state, local and federal agencies are investigating activities at His Majesty's Christian Center. Here are some of the agencies conducting probes and, where available, how much money they paid to the center:

- **Lapeer County Community Mental Health:** Contracted with the home for \$149,138 last year for foster care, apartments and transportation services for 28 clients; plus use of the gym to operate a day treatment program that included rehabilitation services.
- **Lapeer County District Court:** Sent convicts to an unlicensed drug treatment program at the center.
- **U.S. Social Security Administration:** Most residents received disability checks of about \$528 a month, which they paid to the center.
- **U.S. Labor Department:** Approved shelter workshop certificates and special minimum-wage certificates for His Majesty's and an affiliated factory, dating back to 1989.
- **State Department of Labor:** A job-training consortium paid the center about \$5,000 to train half a dozen people over the last two years.
- **State Department of Social Services:** Granted the facility three separate licenses to provide adult foster care for 41 people, and provided food stamps to some residents.
- **State Department of Corrections:** Sent probationers to the unlicensed drug treatment facility.
- **Michigan Commission for the Blind:** Provided funds to train workers at the factory.
- **Michigan Youth Corps:** Sent four youths to do maintenance work at the facility.

Source: United News Research

Where to call to get help

Here are numbers to file a complaint or get information regarding the rights of the mentally impaired:

- **Office of Recipient Rights:** For community mental health officers, phone your local agency. For state officers, 1-800-854-9090.
- **Department of Social Services:** Local offices for Adult Foster Care and Adult Protective Services complaints.
- **Alliance for the Mentally Ill:** (313) 355-0010.
- **Michigan Mental Health Association:** 1-800-462-9534.
- **Michigan Protection and Advocacy:** 1-800-292-5823 or 1-(517)-487-1755.
- **Association for Retarded Citizens:** 1-(517)-487-5426

DeLauter: Allegations of abuse plague care center

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"They called him 'Daddy,' and his wife Helen," DeLauter often hugged male and female residents, they said.

"They always appeared to be cooperative, always available by phone," Berman said.

But Berman refused a request from DeLauter last year for more money to hire job coaches for Otis Lake residents during the winter, saying the state was not paying for the sorting factory owned by DeLauter and associates.

Berman said the factory was not accredited like the state's 79 other "abridged workshops," as mental health policies require.

Still, Berman's staff, who supervised the care provided to 28 clients at Site Majesty's, did not stop them from working at the factory.

"If a client wants to work, we can't stop them," Berman said.

State DSS investigators say residents worked 13-hour days for \$1.50 an hour or less at the factory.

With money coming in from more than eight states, local and federal agencies, Site Majesty's grew last year.

Annual reports filed with the state list last year's gross income at \$13,634 in 1986 to \$104,764 in 1988, with liabilities of \$104,764.

Between 1986 and last year, the Lapeer County mental health agency's contracts with Site Majesty's increased from \$33,000 to almost \$160,000 a year. The agency paid the hours up to \$40 a day for each client.

"I thought (the center) was something that was really making a difference," Berman said. "There were times I thought I'd like to spend two or three days there."

A look back

Key events at Site Majesty's:

- Oct. 6, 1985: Site Majesty's Christian Center is incorporated by David DeLauter and his wife, Marian.
- September 1986: DeLauter is deputized by Lapeer County sheriff to help handle convicts.
- January 1988: DeLauter and associates buy an abandoned factory and open a parts-sorting firm employing handicapped workers.
- September 1989: Local health authorities warn DeLauter he must get a license for his substance abuse program. DeLauter promises to apply but never does.
- Feb. 26, 1991: Police begin investigating reports of sex abuse at center.
- April 1, 1991: State suspends the home's licenses, claiming residents are in imminent danger.
- May 15, 1991: DeLauter is arraigned on eight counts of first-degree criminal sexual conduct involving five mentally retarded women. He is released on \$50,000 secured bond.
- June 5, 1991: DeLauter is bound over for July 15 trial after five female residents testify he forced them to have sex with him.

Like others across the state, the center also collected Social Security disability checks averaging more than \$500 a month from most of the 60 residents.

State investigators also are reviewing Medicaid payments to the center, and the state's use of the residents' food stamps.

Last year, the DeLauters got a \$496,156 mortgage from Lapeer County Bank and Trust and paid Sharrill's real estate firm \$328,000, property records show.

DeLauter and his corporation owe the Lapeer County treasurer more than \$10,000 in back taxes for 1987 and 1988, county records show. Site Majesty's and other businesses in the area, the factory, a tanning salon and a boutique.

Sharrill said a recent appraisal of the complex commissioned by the bank put its value at more than \$900,000.

Jackie's story

Later that February day, as shocked parents arrived at Site Majesty's to sort out the disturbing allegations, a resident named Jackie made a frantic call to a friend who lived nearby.

"She said something real bad is happening," said the friend, Mary. "I just went out and got her. She hadn't been bathed but once or twice a week. Her hair was dirty. She is in a wheelchair and had some all over." Jackie, who has a spine bifida and is schizophrenic, was often punished by DeLauter for "hearing voices," Mary said.

On other occasions, Jackie would be forbidden to use the phone or visit Mary, she said. When Jackie was allowed to call, Mary said she often could hear someone listening in on their conversations.

For months, Mary said, she urged Jackie to file complaints, but Jackie refused.

"She kept saying, 'Where will I go?'"

■ Detroit News Staff Writer Don Teichbart and special writer Thomas H. Duggan contributed to this report.

■ Monday Residents were forced to work long hours, six days a week — for \$1.50 an hour.

HOUSE OF REPRESENTATIVES

Committee on Small Business

Subcommittee on Regulation, Business Opportunities, and Technology

Ron Wyden, Chairman

March 29, 1993

My name is Marlene Carson. I reside in Aloha, Oregon. I have been asked to testify before you today by Congressman Ron Wyden. I am a parent, family advocate and Vice-President of a parent support organization for the developmentally disabled.

Medication caused retardation

My son Douglas Eichler was born on this day, March 29, 34 years ago. He appeared to be a normal active child until he was about 4 years old when his development fell behind other children his age. The mental retardation diagnosis stems from medication given to me by my physician during pregnancy for extreme nausea. Doug was enrolled in special education classes in the second grade and lived at home until age 15, when he was court committed to the Fairview State Training Center in Salem, Oregon due to truancy and run away problems.

Daily diary kept

Since Doug's entry into his fourth providership, I have kept a specific diary of all events including names, dates, times and places.

Downsizing state facilities

When Fairview Training Center began downsizing, the State Mental Health Division promised us his life would be as good as or better than at Fairview. After being transferred into a community setting three times in his 15

Staff stealing food

years at Fairview, in 1990 he was placed in the community again. This was a time of most difficult adjustment. During this period he ran away many times. His problems mounted; his possessions disappeared, food disappeared from his refrigerator as he complained to me that "staff was stealing his food". He lost weight, developed paranoia which precipitated rounds of medication, which had been not previously administered. He became combative, depressed and despondent about his living conditions. The worst mistake that I made as a mother and guardian was not listening to my son as he expressed his fears to me on numerous occasions. The staff and the provider convinced me that Doug's perceptions were inaccurate and unfounded. I have apologized to Doug many times but feel he does not forgive me. He relied upon me to help and I failed him.

I failed my son

I was told that staff was well trained and ready to meet Doug's needs when he was released from Fairview, but in reality their ineptitude to deal with the problems they assured me that they had expertise with had overwhelmed them. I have been asked if the providership was adequately staffed and the answer is an unqualified no.

Staff inadequately trained

Staff were often not present in mandatory numbers, were double shifted, and in one staff to client altercation, the excuse was given that staff had been on duty 72 hours straight. My son was permitted to prowl throughout the night and the area in which he resided and as a result, he was targeted as being a suspect in suspicious activities by the police. This created a very dangerous atmosphere for him and the community. He was on new medication, and because he was not watched properly in very hot weather, suffered a seizure and ended up in a hospital emergency ward. With regard to jobs for Doug and other clients, in order to provide gainful employment, the vocational agency

Police suspect

Vocational program weak

being paid large sums of money by the State of Oregon on a contractual basis, accompanied the client to coffee and doughnut houses and to shopping centers. The vocational program was a weak link in my son's life. In my opinion, the trainer's skills were inadequate to deal with the problems which emerged. The program was a large expenditure of dollars with little or no results or accountability.

State oversights of program providers were frequent but, they did not resolve the problems that arose time and time again.

Information requests ignored

There was little feedback when questions were asked. Phone calls were not returned. When I expressed a concern or interest in the life or care not only of my own son, but of those who lived with him whom I have known for along time, it was made abundantly clear to me that it was none of my business. I have repeatedly asked for financial statements so that I could see where the dollars were going and to assist my son to understand the financial aspects of his life. I have asked for receipts of major expenditures, and after many months of requesting this data, I received a printout of one month's summary expenditures, which I was never able to substantiate as receipts for expenditures were not provided. The month was written in by hand in front of the year on the statement and that document appeared to contain only approximate expenditures at best.

When we asked the Assistant Administrator of the Oregon Mental Health Division where Doug's money went, we were told that this information resided with the service provider. When the service provider was asked for the information, they said that all of that information had been

remitted to the state Mental Health Division and that should be the source of our inquiry. To this day we have received no reply to detailed reconciliation of federal SSI revenues, the use of food stamps for clients, and other supported expenditures. These requests include the most recent one sent by certified mail.

Most clients in MRDD providerships do not have anyone to help them on an ongoing and permanent basis. Caseworkers change as often as four times a year, staff changes monthly, and often, guardians or parents fail to make meaningful contributions. Clients need a constant and consistent person in their lives. They need someone not on the payroll, someone not representing the state or service provider. They need a person they know and trust and who is there for them in an advocacy role when needed. These relationships should be encouraged -- not discouraged or intimidated, and clients should not be punished for their healthy friendships with advocates.

Advocates and clients intimidated

The service provider often sees the advocate, the parent and the family as the enemy. This has to change and it can only change when the provider attitude changes. The client is disenfranchised from the system and their own lives. They are subject to intimidation, harassment, and feel powerless to do anything for themselves. They just plain give up. There are some providers that are exceptions and truly care about their clients and this results in a very successful program. These providers, however, appear to be in the minority.

Some providers say "we want you to be involved" but their every action discourages participation. Do not ask for

kept

details, do not communicate with other parents and do not try to talk to other families. The service provider wants the parent or guardian to be totally uninvolved and that leaves the provider unaccountable and the client and family are isolated.

Downsizing trend

The national trend is to downsize state institutions. For many people community living is a dream come true. But for others it is a nightmare. The way has been paved for agencies of all kinds with all degrees of competency to move into states and provide services for a handsome return on investment. The money tree is alive and growing and abuses are compounding one upon another.

Abuse, fraud and theft

What are these abuses. They include sexual abuse, physical abuse, property theft, theft of cash, fraud, including forged medical records, forged checks, forged signatures including that of the attending physician and medicare fraud. Many of these discoveries were made by lay people, including myself, untrained in the mental health field. All the while these abuses were taking place, records had been certified as accurate by professional state employees. Some would say that this is a small group of isolated cases that should not reflect upon the whole provider system and I would point out to you that these examples are related to just three group homes of one provider in the State of Oregon. This provider has approximately 18 group homes in Oregon and also operates in several other states. Literature on similar events in other states indicates that such cases are much more frequent than many would have you believe. Bad staff who do get fired move on to the next provider and the system makes no attempt to network a method of checking resumes. "Whistle blowers" have been and are

being punished for contacting authorities about these deplorable events. I was informed by others who had been involved as advocates for the retarded for a much longer time, that if we were to become active advocates in these troubling issues, our health, our reputations and our lives would be severely impacted. They warned my husband and I we would be threatened with lawsuit by the provider's legal counsel, that provider and the State of Oregon representatives would and could harm us economically and that we would be threatened by staff of the provider.

Threatened with arrest

All of the above came true. For example, I recently lost a paid advocacy position within the mental health field, for which I was told that I was eminently qualified, following telephone calls to my employer by an Administrator from the State of Oregon and a private service provider. As they viewed it, I was too involved in the advocacy concept and had too many conflicts of interest.

I am Committed

I will continue to be a strong advocate for the retarded and I am committed not to turn my back to problems created by these providers and their friends, representatives of the State of Oregon whose reason for existence is to see that services are provided in a prudent, honest cost-effective manner.

I will not go away

I sit before you, angry, with specific documentation to support each and every thing I have stated. I continue to be an advocate for the retarded and am committed to not go away from problems created by the abhorrent behavior of some providers.

January 5, 1993

Oregon

The Honorable Mary Alice Ford
Chairperson, House Interim Committee
on Human Resources
6620 Hickman Lane
Portland, Oregon 97223

DEPARTMENT OF
HUMAN
RESOURCES

Dear Representative Ford:

MENTAL HEALTH
AND
DEVELOPMENTAL
DISABILITY SERVICES
DIVISION

This is the report on Alternative Services, Inc. (ASI). The report is a follow up to your request after our appearance before the Human Resources Committee on November 19.

Attached you will find a fairly exhaustive summary of all of our monitoring, licensing and technical assistance activities with the three ASI sites in Clackamas County. Although the programs originally opened with good reviews, you will note extensive problems subsequently identified over the course of a year, the same problems shared with your Committee on November 19.

At the time of the hearing we indicated that ASI had undergone a nearly complete change of management in its Oregon operations, including both top and middle management. New management staff were known to the Division by their work with troubled agencies in other counties and for this reason we granted a continuing short time span to allow for program and licensure deficiencies to be corrected.

The reorientation of the agency with new leadership and major changes in personnel has resulted in significant improvement at the three sites in Clackamas County. Most notable has been the progress at the Risley Court site which has been on a limited and conditional license until our last follow-up visit on December 23. Findings now indicate that the program meets our basic licensure standards. However, some deficiencies remain to be corrected, but this is generally the case in most programs that we license.

There are currently 14 residents living at these three sites. ASI intends to vacate one of the sites replacing it with a triplex currently being developed by a private developer. ASI will then lease this triplex as the primary place of residence for five individuals.

As indicated above, based on our extensive monitoring activities we believe marked improvement has been demonstrated and we feel confident that ASI's new leadership and restructured personnel will develop this into a quality program. However, there are other pro-active steps that the Division is planning to take to ensure the program's stability and success. These include:

Barbara Roberts
Governor



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(503) 373-1449
FAX (503) 373-7951

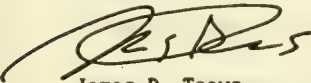
- o In addition to regular licensing visits, we will also conduct unannounced probe visits at these sites at regular intervals.
- o We will assign a case manager to visit the sites weekly.
- o We intend to contract with an independent monitor/behavioral consultant who will visit the program regularly, giving independent feedback to both ASI and the Division. We feel this is especially important because a significant number of the individuals served by ASI have very complex needs, including being dually diagnosed with both mental retardation and emotional problems. Our experience with individuals presenting these problems in agencies all over the State is that there will continue to be some problems and behavioral incidents even under the best of circumstances. But we want to make certain that appropriate behavioral strategies are in place and believe someone with independent expertise can best help us in this regard.
- o We are unhappy with the quantity and quality of vocational services for some of the individuals residing in ASI sites. In this case the vocational provider is a different corporation than ASI. We intend to make program changes to correct these problems.

One area that continues to concern me is the rocky relations between some of the parents and ASI. Within the last month I have met with several parents plus with ASI's top management. I am most interested in breaking down barriers and re-establishing trust and will look for new strategies to do so.

Finally; as I indicated in my letter to you the other day, I am very sorry if I miscommunicated with you regarding our time lines in issuing this report. We stand ready to provide any additional information that you or other Committee members may desire. Obviously the process does not stop here. We will continue to monitor this situation closely and make changes if warranted.

Thank you for your continuing interest and advocacy on behalf of persons with developmental disabilities.

Sincerely,



James D. Toews
Assistant Administrator
for Developmental Disabilities

JDT:as

Attachment

Alternative Services, Inc.
 1651 SE Lava Drive #74 & #86
 Milwaukie, Oregon 97222
 Clackamas County
 Phone: 873-7377

INITIAL APPLICATION

June 19, 1990, application received.

June 20, 1990, CIP pre-license checklist completed by Marsha Beal and Karen Curry.

INITIAL LICENSE

July 15, 1990, temporary license issued (expiration October 15, 1990).

October 18, 1990, extension issued (valid until January 1, 1991).

January 1, 1991, extension issued (valid until April 1, 1991).

AIM REPORTS

August 28, 1990, 4 of 5 categories were excellent; and 1 of 5 was acceptable (safety).

November 5, 1990 3 of 5 categories were excellent; 1 of 5 was good (personal growth); and 1 of 5 was acceptable (safety).

INITIAL ON-SITE

January 18, 1991, initial licensing on-site conducted by Jim Ransom and Karen Curry. Two year license issued (expiration January 18, 1993). Findings:

No major problems identified.

Ten commendations and six recommendations given.

COMPLAINT

June 22, 1992 letter received from Marlene Carson (mother and guardian of one of the individuals). Her issues:

Resistance obtaining medical, program, and financial records for several months.

Conflicting information on where financial records kept. Staff in the home stated they were at the main office in Tualatin. Main office stated they were at the home.

Medical records inaccurate or inconsistent.

Following a meeting with Art Mock, President of ASI and Randall Wardlow, Executive Director (to vent frustrations), she called the home to inquire as to the well being of her son. Staff indicated to her they did not know his whereabouts. She felt they would not have informed her of his absence, and that missing notification timelines set by the ISP team had not been followed.

UNANNOUNCED ON-SITE

July 7 and 8, 1992, unannounced on-site conducted by Barbara Southard and Teresa Ritner. Problems identified in the following:

Medical management area:

Confidentiality issues due to misfiling MARs.

Policies and procedures did not reflect current practices (five examples given).

X Monitoring of individuals health and timely interventions not occurring; e.g., one individuals scheduled visits to the physician for allergy desensitization injections had been missed, another individual's follow-up appointment had not occurred as ordered, and weights and blood pressures were not obtained as ordered.

Records not complete regarding allergies and known communicable diseases.

Missing documentation to reflect visits to health professional and consultation or therapy provided; e.g., record did not reflect weekly blood draws for one person.

Physician's orders not followed.

Medications not kept secured (by observation).

MARs were not complete.

A number of medication administration irregularities (one observed during the visit) and reviews were inconsistent.

X 90 day medication reviews not occurring consistently.

Documentation not kept for all disposed drugs.

X Health (food and nutrition) area lacked documentation that meals were: well balanced; provided in a number consistent with the community; and met the needs and preferences of the individuals, including special diets. One apartment did

not contain sufficient food for the individual living there. Food storage, temperature and sanitation, were issues.

Safety (general) issues:

Flammable and toxic material were not stored appropriately.

Hot water temperature exceeded 120 degrees.

Personnel records were not complete; e.g., missing items included documentation of CPR & first aid, references, TB testing, and pre-service and inservice training.

Incident reports not sent to case manager as per rule, and missing notification not followed as determined by the ISP team.

Evacuation drills were not occurring as specified in the rule, especially nighttime ones.

Rights, general issues:

Training programs not implemented as per ISP team agreement, and behavior supports and documentation of such not found.

X Adequate food not found in each apartment.

X Follow-up not found as per ISP team specifications for 15 minute bed checks on individual who fell out of bed (special bed being pursued) —?

now it's a problem!
ISP team meetings needed to address phone restrictions for one individual, locked cigarettes for another individual, and privacy for individual in apartment with office (program business conducted in her living area).

ISP teams to be convened and to include the individuals.

Document notification regarding programs policies and procedures.

Confidentiality issues; e.g., information misfiled, and records for everyone maintained in the general living area of one individuals apartment.

Behavior intervention issues:

Functional analysis not found.

Consents to plans, by ISP team, needed for all individuals (include on ISP).

Implementation and documentation of programs not maintained.

For one individual hourly checks (9:30 pm to 7:30 am), and two hour checks (7:30 am to 9:30 pm) not conducted.

Tracking sheets found for all individuals, yet no data maintained on them. ISP team clarification needed.

for
Stoff Documentation needed regarding notification of policies and procedures. -

Medications for behavior issues:

Team approval needed and medications needed to be included on ISPs.

Documentation of balancing test not found (in process).

No documentation found to indicate medications were monitored for effectiveness on the targeted behavior.

Money issues:

Policies and procedures not implemented.

Records not maintained accurately. (Problems in documentation of individuals funds.)

ISPs did not reflect double signature accounts.

Individuals accounts had not been reconciled with bank statements.

Personal property records were not current.

Personal dresser on one individual was not accessible to him

~~+~~ Program management, documentation problems found in all areas.

PROTECTIVE SERVICE

August 1992 conducted. Licensing unit told to wait until completed before going back in.

NEW EXECUTIVE DIRECTOR

August 31, 1992, letter to Jessie Martin stating missing documentation from the home and procedures to be implemented to rectify the situation.

MONITORING VISITS

September 17, 1992, monitoring visit conducted by Barbara Southard and Teresa Ritner.

Correction noted in the following:

Confidentiality.

Individuals care, appointments kept.

Weight and blood pressure occurring as ordered.

Allergies addressed.

Chest x-ray results had been obtained.

Improvement noted in documentation on September HARS. *when are they going to be*

Administrative reviews found for medication administration irregularities.

Safety, general:

fire alarms - ?
Toxics and flammables stored safely.

Hot water temperature corrected.

First aid kits available in each apartment.

Documentation for drills corrected.

Rights:

Food available in all apartments. *- what kind of food?*

Documentation found that ISP teams addressed phone restrictions, and locked cigarettes.

X The program had moved its office with in the apartment. Two individuals switched places (placing person requiring more staff assistance and monitoring close to staff office). *Still conducting business in client apt.*

X Individual furnishings, individual had access to dresser. *As per worksheet 1 month before he moved out! Was never have gone rec'd but on*
Problems in the process of being addressed or noted as ongoing issues:

Possible reaction to medication for one person had yet to be clarified. (Ongoing)

X Lab screenings, continued inconsistent documentation. (Ongoing) *Client not told of result of own tests.*

Physicians order not followed. Physician informed but no documentation found (telephone order) regarding his instructions. *Doctors become very frustrated as orders are not tracked for client monitoring. Appt. not kept etc.*

No discontinuation order for thick-it.

Inconsistent documentation of prns continued.

Food and nutrition issues in process of being addressed.
(Ongoing) *as of Jan. 93 - dietitian notes not being followed.*

Refusal by two people to participate in sleep time drills.
No further attempts documented. (Ongoing)

X Medications for behavior issues continue. *increased meds.*

X Personal property record issues continue.

X Money records being reviewed at corporate office. (Ongoing) *NO. missing Oct. 92*

Program management issues, correction in process.

Every time you try to deal with issues - face new employee.

October 21, 1992, monitoring visit conducted by Barbara Southard, Sue Birge, and Teresa Ritner.

Correction noted in the following:

X Appointments kept for allergy injections (occasional *M. L. and Sunday* refusal by the individual). - *Card outdated or forgotten by staff.*

Documentation reflected the physician kept informed of medication refusals, and overall improved documentation regarding health issues.

Telephone orders had been obtained, and were awaiting physician's signature.

90 day medication reviews were current.

Drug disposal records were up to date.

X Special bed in process of being ordered. *hasn't been ordered yet!*

Documentation of notification of programs policies and procedures noted.

Progress in implementation and documentation of behavior intervention programs.

Medication irregularities had documentation of review.

Problems that continue:

X Issues with medical policies and procedures continue.

Individual care documentation did not reflect physician aware of continued incidents of vomiting. Nor was it clear staff monitoring was occurring. (Ongoing)

One individuals possible reaction to medication still missing clarification. (Ongoing)

Lab screenings had improved documentation. (Ongoing)

Incident reports had appropriate information found, however, administrative reviews needed more than statements that policy followed. (ongoing)

General, drill requirements had progress being made.

* Documentation needed that individuals notified of behavior policies and procedures.

Medications for behaviors:

Balancing tests in process of being obtained. (Ongoing)

Monitoring for the effectiveness of the medication continues to be a problem. (Ongoing)

Money and property records not reviewed. They were at the corporate office.

Program management documentation of individual vomiting was not found. (*New)

PROGRAMS RESPONSE TO MONITORING VISIT

Love Drive
Brook Lampe - \$700.00 missing.
 House manager removed following 10/21/92 monitoring visit.
 Jonnie Humphrey managed the home until new manager hired.

MONITORING VISIT

December 9, 1992, monitoring visit conducted by Barbara Southard and Teresa Ritner.

Correction noted in the following:

Issue regarding possible medication reaction resolved, documentation in the record.

Drug disposal records were complete.

Money management issues resolved. Review of two files revealed complete documentation of earnings and expenditures.

X Program management no longer an issue. Documentation was complete. *why was case mgmt. doc. not complete to start with.*

Rights issue, hospital bed awaiting approval by medicare. X
has this been resolved?

Problems that continued:

Confidentiality issues due to misfiled records. (*New)

Medical management policies and procedures, correction in progress. (Ongoing)

Care of individual vomiting still an issue. Physician not being kept informed of programs inability to accurately track incidents. *why doesn't*

All physicians orders followed but one. The individual received the wrong medication dosage. (*New)

MARs had unexplained blanks. (Ongoing)

Administrative review of individual receiving wrong dosage not reviewed. (Ongoing)

Fire drills, none conducted in November. (Ongoing)

MH_DDPRL.IB/TERRY/ASI.L

Alternative Services, Inc.
 8640 SE Causey Avenue
 Portland, Oregon 97266
 Clackamas County
 Phone: 691-1124
 (Previous Address: 4553 SE Brookside Drive
 Milwaukie, Oregon 97222)

INITIAL APPLICATION

November 9, 1990, application received.

No CIP pre-certification checklist on file.

INITIAL LICENSE

November 27, 1990, temporary license issued (expiration date March 26, 1991).

INITIAL ON-SITE

March 21, 1991, initial on-site conducted by Sue Birge and Sue Pack, two year license issued (expiration date November 20, 1992).

April 11, 1991 corrective action plan submitted by ASI.

SITE MOVED

December 30, 1991, Sue Pack, Service Coordinator notified Jessie Martin of site address change to SE Causey Avenue.

January 14, 1992, application received.

INITIAL LICENSE OF NEW SITE

January 22, 1992, temporary license issued (expiration date April 22, 1992).

April 19, 1992, licensing on-site conducted by Jim Ransom, Gretchen Koch, and Leo Henry. Findings:

Two year license issued (expiration date January 22, 1994).
 Plan of correction requested to be submitted in 30 days.

Problems identified in medical service area (monitor prosthetic devices, physicians orders, MARs, and self-administration). Additionally problems identified with personnel records, fire evacuation (no training upon entry), confidentiality of records, behavior management (functional alternatives), medications for behavior (no balancing test and medications not address on ISPs), and general documentation (not always dated and signed).

Four commendations and four recommendations were given.

COMPLAINT INVESTIGATIONS

May 8, 1992, site visited by Jim Ransom "...to respond to anonymous concerns regarding lack of food, first aid kits and flashlights in residents apartments, disgruntled staff." Findings:

Lack of food in one individuals apartment was substantiated. Staff reported the lack of food was due to the individuals history of property destruction, overcooking food creating a fire hazard, mixing raw food materials, and throwing food outside the apartment. An ISP note stated, "Behavior plan to be developed." No parameters for food removal (or reason why) were documented on the individuals ISP, latest functional analysis, communication log or any other document found.

MONITORING VISITS

July 13, 1992 monitoring visit conducted by Barbara Southard and Teresa Ritner.

Problems/issues identified included some that had been identified on the last on-site and several new issues:

Medical/health issues:

One individual's immunization series for Hepatitis B had not been completed. (*New)

Documentation on MARs was not always complete. (Ongoing)

Safe storage of a self-administered medication (Epi-pen) was an issue. (Ongoing)

Nursing assessments were not in individual records (progress notes reflected they occurred). (*New)

A physician's order for one person indicated medications they could be self-administered, however, this was not addressed on the individual's ISP. (*NEW)

Diet and nutrition was an issue. Documentation was not found reflecting menu cycles were followed. Also, raw frozen chicken had been laid on the counter to thaw (by one of the individuals in the home) instead of inside the refrigerator. (*New)

Money management issues:

Question of whether personal funds used to repair the homes TV. (*New)

One individual had a check (issued 4/30/92) in the home that had not been deposited. (*New)

Individuals did not have access to their money (house manager ill and no other staff person able to access money). Abilities or limitations for individuals to manage money not addressed on ISPs. (*New)

Training programs were not occurring as scheduled. (*New)

Behavior management issues:

One individual had a PSRB requirement that staff check with him every 30 minutes. No documentation was found for May, June, or July that these checks occurred, nor that procedures for walking to work (unsupervised) were followed. (*New)

Not all behaviors (on tracking forms) resulted in incident reports. (*New)

Behavior plans not implemented. One persons called for a two person hold (staffing at night consists of only one person, no plan in place to address this). (*New)

October 30, 1992, monitoring visit conducted by Roland Brown and Leo Henry (plan of correction required). Concerns identified during the visit:

Medical management:

Orders not followed. (Ongoing)

Medications not kept secured, locked. (*New)

Administrative review of medication administration irregularities not occurring. (Ongoing)

Rights, an individuals program was not consistently implemented. (*New)

Grievance not found for an individual who allegedly had one. (*New)

Behavior management issues:

Plans need to address functional alternatives. (Ongoing)

Documentation needed regarding informal behavior interventions. (*New)

PROGRAMS CORRECTIVE ACTION

Plan of correction submitted by ASI November 10, 1992.

MONITORING VISIT

December 9, 1992, a monitoring visit was conducted by Barbara Southard and Teresa Ritner.

The program had addressed issues previously cited:

Medications were securely stored.

MARs reflected correct administration time as specified on the physician's order.

Incident reports were reviewed and forwarded to the program manager and case manager in a timely manner.

Grievances issue had been addressed (discussed by the ISP team). However, documentation needed of the resolution.

Problems still noted:

OT evaluation had yet to be obtained as ordered. New manager indicated they were to be scheduled. (Ongoing)

Heel cord stretches had not been addressed as ordered. New manager indicated they were to be addressed. (Ongoing)

Staff had not yet been trained by OT/PT to provide ordered interventions. New manager indicated training to be scheduled. (Ongoing)

No incident report (nor any other documentation) found addressing why Tegretol ordered 8/4/92 (by a previous psychiatrist) was never initiated. (ongoing)

Behavior management plan for one individual had not been implemented. (Ongoing)

MH_DDPRL.IB/TERRY/ASI.C

Alternative Services, Inc.
15323, 15325, 15327 Risley Court
Milwaukie, Oregon 97222
Clackamas County
Phone: 691-1124

INITIAL APPLICATION

January 35, 1990, application received.

February 1, 1990, CIP pre-license checklist completed by Marsha Beal and Leigh Gerhart.

INITIAL LICENSE

February 16, 1990, temporary license issued (expiration date May 31, 1990).

INITIAL ON-SITE

May 30, 1990, initial on-site conducted by Al Mumford and Jennifer Gilbertson. Findings:

Two year license issued (expiration date February 1, 1992).

No major issues identified.

Seven commendations and five recommendations noted.

PROGRAMS RESPONSE

JUNE 26, 1990, corrective action plan submitted by ASI.

ON-SITE

December 16-17, 1991 licensing on-site conducted by Jim Ransom and Gretchen Koch. Findings:

120 day license issued (expiration April 17, 1992).

Problems identified in medical management, food and nutrition, safety(general), personnel, emergency plan and safety review, evacuation drills and fire safety, rights (general), behavior intervention, handling and managing individuals money, personal property, and documentation requirements.

PROGRAM RESPONSE

February 3, 1992, plan of correction submitted to MHDDSD.

TECHNICAL ASSISTANCE

February 7, 1992, technical assistance given to the site by Teresa Ritner on medical records (documentation), and identifying and addressing medical support needs.

MONITORING VISIT

February 18, 1992, conducted by Jessie Martin

Problems that had been addressed;

CPR/First Aid training provided to staff 2/17/92.

Summary sheets updated.

Medication administration training by IPAC 2/18/92.

Consultation by Speech and Language consultant 2/18/92.

Problem noted:

Orders not current for two individuals.

Documentation did not reflect blood level obtained as ordered.

PT and OT services not obtained as ordered (program states unable to find consultants).

One individuals appointment at county Mental Health Clinic not kept.

Emergency telephone numbers needed to be updated (two apartments).

One individuals behavior plan not signed off by case manager.

Delay in program manager reviewing incident reports.

Incident reports regarding behaviors did not always have corresponding tracking data.

No system to communicate/obtain critical information from work site regarding behavior needs.

Behavior intervention not implemented as written for one individual.

Communication system not utilized for one individual as per plan.

February 28, 1992 a monitoring visit was conducted by Jim Ransom and Leo Henry.

The program had addressed several issues:

90 day medication reviews had occurred for all but one person.

Individual referred to specialists (oculist and ophthalmologist) for irritation from prosthetic (glass eye).

No issues identified with individual self-administering their own medication.

Fire-drill records were noted to complete.

Behavior programs had been initiated.

Individual reimbursed for lost communication device.

Problems that were noted:

Protocol/procedure not found for "cleaning outer ear canal, and dry with hair dryer."

Documentation of prns not complete.

Administrative review not occurring for all medication administration irregularities.

Staff not clear why monitoring ordered, so unclear what to report.

Emergency phone numbers not current.

Staffing issues (added F.T.E. not filled).

Laundry soap and cleaning supplies unlocked. (Ongoing)

Personal property records not current.

One individuals' personal money record not detailed so as to reflect transactions (deposits).

FOLLOW-UP ON-SITE TO LIMITED LICENSE

April 8, 1992, follow-up licensing on-site conducted by Sue Birge, Dawn Bergstrom, Jennifer Gilbertson, and Jessie Martin. Findings:

Six month license issued (expiration date October, 9, 1992).

Problems previously cited that had been addressed:

Confidentiality.

Program had implemented their policy on medication administration errors.

PT and OT assessments had occurred.

Prosthetic device added to ISPs.

Medical records organized so that information was easily accessed.

Information was available regarding TB screening, immunizations and allergies.

Current orders found for medications, treatments, and prosthetic devices.

MARS were complete, documentation reflected medications administered.

90 day medication reviews current.

Administrative review found for medication administration irregularities.

Dietary consultation scheduled for individuals on special diets.

Program had hired additional F.T.E. (as funded).

Problems identified:

Physician order for ear plugs for one individual followed and documentation accurately.

Screen doors to be obtained (doors left open).

Safety (general) issues were unlocked toxic materials (no variance), and missing heater control knob in one bathroom.

Emergency plan and safety review (numbers not posted near phones.

Evacuation drills and fire safety (sleep time drill, 1/30/92, for only two of five individuals).

Behavior intervention programs for two individuals not implemented as scheduled.

Previous personal property records could not be located, so unclear if they were complete.

Documentation requirements; i.e., entries not always dated and complete.

PROGRAMS RESPONSE

May 18, 1992, a corrective action plan was submitted by ASI.

MONITORING VISITS

June 9, June 25, and June 30, 1992 monitoring visits were conducted by Leo Henry. New house manager noted for the site along with numerous other staff changes.

Progress noted in the following:

PT assessment found for individual with need for hand splint identified (splint being ordered).

No critical medical incidents had occurred since last visit.

Problems identified:

Communication device (Talk-Machine) was to be replaced.

An individual needed to be reimbursed funds used to pay for repair of homes TV.

Emergency numbers needed to be posted by staff phones.

April 28, 1992 two individuals did not participate in "sleep hour" fire drills, no subsequent attempts found for these two individuals.

Training programs (communication and relaxation) had not been implemented in June for one individual.

Screen doors for two apartments needed to be installed.

July 10, 1992, a monitoring visit was conducted by Barbara Southard and Teresa Ritner.

The program had addressed administrative review of medication irregularities. Additionally, the "Talk-Machine" was delivered (the day of our visit, staff training to occur).

Problems identified:

No documentation indicating the physician was aware of one persons medication refusals.

90 day medication reviews still not occurring in a timely manner.

Plans by the PT and OT had not been implemented.

Training programs were not occurring as scheduled.

A self-administration program changed due to incorrect transcription on the T.A. (also, wrong day punched out from bubble pack).

Reimbursement for repair of homes TV had not yet occurred.

Behavior tracking sheets for two individuals were reviewed. Not all incidents recorder had corresponding incident reports.

Training programs were posted on walls in other individuals apartments.

Bleach and floor wax were stored in unlocked cupboards (no variance).

Documentation in program books missing month and year.

The policy and procedure manual was locked in the office and thus not available to staff (only the manager had the key to the office).

August 17, 1992, a monitoring visit was conducted by Sue Birge and Gretchen Koch.

Two items were noted to have improved. One individual was seen by the physician on the day of the review. Information from that visit was entered into his file that same day. Additionally, a review of the house log revealed no rights violations.

Problems identified during the visit:

90 day medication reviews not current. (Ongoing)

Medications found in an unlocked file cabinet. *(New)

Doors and screen doors to apartments found open with no one inside. One apartments door jam in disrepair. *(New)

September 10, 1992, a monitoring visit was conducted by Barbara Southard, Sue Birge, and Teresa Ritner.

Several positive items were noted:

Results of prn medication could be found.

One individuals ISP held 8/31/92 was ready to start 9/10/92.

Follow-up on incident reports were found.

Problems still occurring:

Individual self-administering her medication continued to have problems dispensing (punching out incorrect day from bubble pack). (Ongoing)

Augmentative communication device "Talk-Machine" not on individuals ISP, and not available to the individual at all times. (In process of being addressed. Communication specialist to determine if appropriate 9/13/92). (Ongoing)

Behavior data had about 75% with corresponding incident reports. (Ongoing)

Cleaning supplies in unlocked cupboard. (Ongoing)

One dresser broken, bedroom curtain missing one bedroom, and bedroom curtain rod broken in another bedroom. *(New)

Doors to all apartments open and not all people home. (Ongoing)

FOLLOW-UP ON-SITE TO LIMITED LICENSE

October 7, 1992, licensing on-site conducted by Jim Ransom, Barbara Southard, and Gretchen Koch. Findings:

90 day license issued (expiration date January 7, 1992).

Progress noted:

System change was for direct care staff to read all consultant reports.

Orders were current.

Protocol developed regarding missed medications.

Problems identified:

Medical management, develop procedure for ear cleaning, (ongoing). Timely monitoring of individual health status. Follow physicians orders for weekly weights, missed nutritional supplement and refused medications. Documentation on MARs not consistent for effectiveness of prns, (ongoing). Signatures missing on MARs including individual who self-administers.

Inconsistent documentation of administrative review of medication administration irregularities.

Physical environment (carpet repair needed which had been reported to the landlord) and place screen doors on apartments. Curtains need to be placed in bedrooms. (Ongoing)

Personnel issues; e.g., signed job descriptions (2), TB screening (3), pre-service documentation, (in process of correction).

Incident reports were not found for behavior issues documented on tracking forms. (Ongoing)

Administrative review of incident reports were not timely.

Vehicles, weekly maintenance check lists not complete. Also, sliding side door on van needed repair.

Evacuation drills and fire safety included: sleep time drills not occurring ever three months (ongoing). Also, address three individuals refusals to participate in fire drills on their ISPs. Plan needs to be developed with case manager, local fire authority and request a variance, as needed.

Rights (general), implement and document ISP training and behavior intervention goals.

Provide written guidelines for self range of motion.

Document what supports in place for individual self administering their medications

ISPs to be updated to address health related supports.

Document notification two individuals guardians informed of rights, grievances and behavior intervention policies

Implement, review and document behavior interventions. Document ISP team and guardian consent to behavior interventions.

Medications for behaviors to be included on ISPs, be monitored, and reviewed.

Money management, reconcile all individuals accounts, insure checks deposited in timely fashion, that accounts do not exceed \$2,000, and amend policies and procedures to establish weekend procedures. Entries to

be made in a timely fashion, and that policies and procedures are followed regarding record reviews.

Personal property issues remain unchanged.

Plan and assessment, ISPs not current; i.e., signed by case manager.

Documentation requirements issues continue.

MONITORING VISITS

October 21, 1992, conducted by Barbara Southard, Teresa Ritner, and Sue Birge. Findings:

Progress noted in the following:

Health issues were addressed in timely manner.

Prns had complete documentation.

Administrative reviews of irregularities found.

Menus reflected well balanced diets.

Incident reports sent to case manager in a timely manner

Behavior data being collected.

Range of motion being initiated. Visual instructions in place and staff starting to be trained.

Notification of policies and procedures completed.

Documentation requirements (some progress noted).

Problems noted:\

Two instances of orders not followed. (Ongoing)

Transcription error resulted in medication (topical) not being administered as ordered. *(New)

Signatures not on all MARs. (Ongoing)

Physical environment, carpet not repaired. (Ongoing).

A bedroom door for one individual needed to be repaired. *(New) Screen doors still not in place. (Ongoing) Front window screens in need of repair. *(New) Window covering still missing. (Ongoing)

Incident reports needed more detail. (Ongoing)

Van door not repaired. (Ongoing)

Rights (general), implementation of ISPs still to be resolved with county.

Augmentative communication device not addressed on behavior plan. (Ongoing)

Implementation of behavior programs not completed, plans not updated (case manager had not signed).

Consent to behavior programs continue to be worked on resolving this issue (case manager and program).

Medications for behavior not addressed on ISPs, and monitoring and review (Ongoing)..

December 9, 1992, conducted by Barbara Southard and Teresa Ritner. Progress was noted in several areas:

Medical management:

Individual care.

Physicians orders obtained and followed.

Documentation on the MARs complete on the two records reviewed.

90 day medication reviews had recently occurred.

Nutritional needs of individuals in the process of being addressed.

Physical environment issues in process of being addressed. Work orders noted for carpet coming up and bedroom door that would not close.

Safety (general) issues regarding window coverings for privacy and working flashlights had been addressed.

Safety (vehicles and drivers), correction noted. Van door had been repaired.

Safety (evacuation and fire drills), correction noted. Drills ran, training program developed and on the ISP.

Rights (general), progress noted. Documentation reflected consensus and implementation of ISPs and behavior goals. Also, electric communication device for one individual addressed on his ISP.

Rights (behavior interventions), correction noted. ISPs had been signed.

Rights (medication for behavior), progress noted. ISPs signed and monitoring of behavior occurring.

Plan and assessment, correction noted. ISPs signed.

Program management, progress noted.

One new problem was identified in the area of Health (food and nutrition). Menus did not reflect how special diets were addressed.

FOLLOW-UP ON-SITE TO LIMITED LICENSE

December 23, 1992, licensing on-site conducted by Jim Ransom, Steve Schmidt, and Gretchen Koch. Findings:

Progress:

Special protocols to address health needs in place.

Documentation of health issues easy to follow.

Documentation markedly improved on MARs, progress notes, incident reports, telephone orders, and review of follow-up on medication administration irregularities.

Privacy coverings for bedroom windows had been addressed.

Regarding fire issues all persons either able to exit, in training, or have a plan in place. (Good documentation on training and procedures.)

Money records well organized, and reconciled.

Personal property records complete.

Carpet issue had been addressed.

Screen doors and windows had been addressed.

Bedroom door repaired.

ISP goals and objectives implemented and documented.

Augmentative communication device addressed on behavior plan.

Behavior programs updated and implemented.

Consent for behavior program from ISP team members and guardians.

Problems:

Written approval of variances to be obtained.

One individual had expired orders

One individual did not have current 90 day medication reviews.

Graveyard shift not consistently staffed with CPR/First Aid certified individuals. (Staff to be certified within six months of hire.)

Incident reports did not address what actions taken to insure incident did not reoccur.

Monthly safety reviews not consistently conducted.

Exit routes and location of fire not varied.

Special supports regarding fire evacuation needed to be noted for two individuals.

Rights (general), support needs for individual on Lithium needs to be specified.

Authorization for use of physical restraints to be obtained.

Medications for behaviors to be included on ISPs, monitored, and reviewed. (Ongoing)

\$3665.32
Service Payment
Mont. K.

Alternative Services of Oregon, Inc.
Expenses for Doug Eichler

5/92

Not Verified - 4500 audit picture for month of Oct.
Little banking for the situation. To make sure
Direct Costs on the whole. Hospital did not happen.
Rent \$395.00 - See calculation with
Electricity 22.85
Telephone 27.59
Other Utility Expense 20.00
Consultations 253.41
Total 718.85

Allocated Costs
Emerging Call Systems \$ 3.20
Insurance 18.80
*Other General Maintenance 79.00
Activity Materials 19.43
Food 161.81
Household Goods 33.41
Office Supplies 5.36
Transportation 171.38
Employee Recruitment 10.95

503.34

Total Costs

\$1222.19

*See attached voucher

(503) 659-2777 • FAX (503) 659-1005

AMOUNT ENCLOSED
\$75.00

375.00

OK
MW
5-12-92
#04

PLEASE DETACH AND RETURN WITH YOUR REMITTANCE

WAVERLEY GREENS APARTMENTS

DATE		DATE	
DATE	DESCRIPTION	CHARGES	CREDITS
BALANCE FORWARD ►			
5/10/92	Repairs on the following		
B86:	Door Frame Broken		
B74:	1) Replace door stop 2) Repair door behind front door 3) Replace light cover 4) Repair accordion door		
B61:	1) Repair carpet at entrance to 2) Repair hole in R/R wall 3) Replace light above sink 4) Repair closet doors L/R		
B86:	1) Repair hall closet doors 2) Repair door by door touch up paint again 3) Patch face of cut line 4) Replace/Repair handle on shower 5) Replace front door handset		
B69:	1) Repair holes behind front 2) Replace rack inside refrigerator 3) Replace grill at bottom of refrigerator and stand for refrigerator 4) Replace toilet paper holder 5) Repair wall 6) Repair balance on verticles 7) Replace knob on dimmer 8) Replaced one door stop.		

If you have any questions, please call. Thank you.

Thank You

ANY LAST THOUGHTS
IN THIS COLUMN?

Alternative Services of Oregon, Inc.
 Start-Up Expenditures
 Doug Eichler

Not to Profit

Wages and Fringes		
Area Supervisor	\$ 504	
Home Supervisor	239	
Direct Care	876	
Payroll Taxes	285	
Workers' Compensation	<u>89</u>	
		\$1,993
Rent		116
Utilities		
Electricity	\$ 6	
Telephone	40	
- Other Utilities	- 4	
		50
Maintenance		17
Activity Supplies		27
Consumables		
Food	\$ 95	
Housekeeping Supplies	201	
Office Supplies	<u>72</u>	
		368
Miscellaneous		166
Furnishings and Equipment		
Appliances	\$ 399	<i>micid-TV?</i>
Fire & Safety Equipment	32	
Furnishings	2,915	<i>rest of FS</i>
Kitchenware	335	
Office Equipment	<u>151</u>	<i>what for? what situation?</i>
Linens	<u>209</u>	
		<u>4,647</u>
		\$7,384
		=====

ALTERNATIVE SERVICES-OREGON, INC.
LAWY DRIVE

STATEMENT OF REVENUE AND EXPENSES COMPARED TO BUDGET
FOR THE PERIOD FROM MAY 1, 1992 TO MAY 31, 1992

	CURRENT QUARTER				YEAR TO DATE			
	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE
OPERATING REVENUE:								
PER DIEN REVENUE:								
CONTRACT REVENUE-BDSB	\$ 18,327	\$ 18,327	181.7	\$ 0	\$ 201,557	\$ 201,596	94.9	\$ 1
WAGONBONGU	1,676	3,487	10.0	1,729	12,452	12,779	5.6	199
RENT SUBSIDY	630	630	3.5	0	6,930	6,930	3.2	0
OTHER	0	0	0.0	0	0	0	0.0	0
OTHER	0	0	0.0	0	0	0	0.0	0
OTHER	0	0	0.0	0	0	0	0.0	0
OTHER	0	0	0.0	0	0	0	0.0	0
FOOD STAMPS	0	0	0.0	0	0	395	0.1	395
TOTAL PER DIEN REVENUE	\$ 20,633	\$ 22,364	124.1	\$ 1,729	\$ 226,985	\$ 227,269	107.0	\$ 275
OTHER OPERATING REVENUE:								
JOB TRAINING/WAGE SUBS	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
CONTRACT REVENUE	0	0	0.0	0	0	0	0.0	0
DIVERSIGN REVENUE	0	0	0.0	0	0	0	0.0	0
MEDICAL REIMBURSEMENT	0	0	0.0	0	0	0	0.0	0
UNEMP DIME REVENUE	0	0	0.0	0	0	0	0.0	0
TOTAL OTHER OPERATING REVENUE	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
TOTAL OPERATING REVENUE	\$ 20,633	\$ 22,364	124.1	\$ 1,729	\$ 226,985	\$ 227,269	107.0	\$ 275
OPERATING EXPENSES:								
WAGES AND FRINGES:								
PROGRAM MANAGER	\$ 640	\$ 484	2.2	\$ 236	\$ 7,040	\$ 5,087	2.7	\$ 1,254
HOME NGR/BENNY SPEC	1,970	1,895	10.5	83	21,750	21,041	9.9	717
DIRECT CARE	7,284	7,590	42.1	386	80,124	86,366	40.6	6,242
IN-SERVICE TRAINING	0	0	0.0	0	0	0	0.0	0
VACATION & SICK PAY	612	426	2.3	186	6,732	2,156	1.0	4,576
ONE-TO-ONE PAYROLL	0	0	0.0	0	0	0	0.0	0
CLINICAL	0	307	1.7	387	0	313	0.1	313
OTHER WAGES	0	0	0.0	0	0	10	0.0	10
PENSION PLAN EXPENSE	0	0	0.0	0	0	0	0.0	0
PAYROLL TAXES	1,157	893	4.9	264	12,727	12,565	5.9	162
GROUP INSURANCE	1,000	156	0.8	1,244	11,960	3,492	1.6	8,475
WORKERS COMPENSATION	2,607	000	4.4	2607	12,797	12,241	5.7	644
TOTAL WAGES AND FRINGES	\$ 13,716	\$ 12,163	97.0	\$ 1,553	\$ 133,870	\$ 124,071	97.0	\$ 9,805

ALTERNATIVE SERVICES-DREDM, INC.
LAWA DRIVE

STATEMENT OF REVENUE AND EXPENSES COMPARED TO BUDGET
FOR THE PERIOD FROM MAY 1, 1992 TO MAY 31, 1992

	CURRENT QUARTER				YEAR TO DATE			
	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE
SHELTER:								
RENT	\$ 1,860	\$ 1,720	9.5	\$ 140	\$ 20,460	\$ 19,263	9.0	\$ 1,197
DEPRECIATION	0	0	0.0	0	0	0	0.0	0
PROPERTY TAX	0	0	0.0	0	0	0	0.0	0
TOTAL SHELTER	\$ 1,860	\$ 1,720	9.5	\$ 140	\$ 20,460	\$ 19,263	9.0	\$ 1,197
UTILITIES:								
ELECTRICITY	\$ 217	\$ 145	0.8	\$ 72	\$ 2,307	\$ 2,582	1.1	\$ 115-
HEAT	0	0	0.0	0	0	0	0.0	0
TELEPHONE	300	208	1.6	12	3,300	3,005	1.4	295
WATER AND SEWAGE	0	0	0.0	0	0	0	0.0	0
SEWITATION	0	0	0.0	0	0	25	0.0	25-
SEPTIC SERVICE	0	0	0.0	0	0	0	0.0	0
OTHER UTILITY EXPENSES	50	92	0.5	42-	550	651	0.4	301-
EMERGENCY CALL SYSTEM	34	16	0.0	16	374	267	0.1	107
TOTAL UTILITIES	\$ 601	\$ 541	3.0	\$ 60	\$ 6,611	\$ 6,656	3.1	\$ 45-
INSURANCE	\$ 210	\$ 94	0.5	\$ 116	\$ 2,310	\$ 962	0.4	\$ 1,348
ROUTINE MAINTENANCE:								
LAWN CARE & SNOW REMOVAL	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 9	0.0	\$ 9-
PEST CONTROL	0	0	0.0	0	0	0	0.0	0
OTHER GENERAL MAINTENANCE	50	375	2.0	325-	550	1,057	0.5	507-
TOTAL ROUTINE MAINTENANCE	\$ 50	\$ 375	2.0	\$ 325-	\$ 550	\$ 1,066	0.5	\$ 516-
MAJOR REPAIRS	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
ACTIVITY MATERIALS	\$ 75	\$ 97	0.5	\$ 22-	\$ 825	\$ 922	0.4	\$ 97-
CONSUMABLE SUPPLIES:								
FOOD	\$ 866	\$ 887	4.4	\$ 57	\$ 9,526	\$ 9,403	4.4	\$ 123
HOUSEHOLD GOODS	99	167	0.9	68-	1,089	2,895	1.3	1,806-
CLOTHING	0	0	0.0	0	0	0	0.0	0
OFFICE SUPPLIES	25	27	0.1	2-	275	267	0.1	8
DEPRECIATION	0	0	0.0	0	0	0	0.0	0
OTHER	10	0	0.0	10	110	110	0.0	0-
TOTAL CONSUMABLE SUPPLIES	\$ 1,000	\$ 1,083	5.5	\$ 3-	\$ 11,000	\$ 12,683	5.9	\$ 1,683-

ALTERNATIVE SERVICES-OREGON, INC.
LAVA DRIVE

STATEMENT OF REVENUE AND EXPENSES COMPARED TO BUDGET
FOR THE PERIOD FROM MAY 1, 1992 TO MAY 31, 1992

	CURRENT QUARTER				YEAR TO DATE			
	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE
TRANSPORTATION:								
VEHICLE LEASE	\$ 325	\$ 340	1.0	\$ 14-	\$ 3,586	\$ 10,618	5.0	\$ 7,024-
UTILITIES & INFORMATION	0	0	0.0	0	0	0	0.0	0
FUEL	110	251	1.2	121-	1,210	3,004	1.0	994-
MAINTENANCE	0	0	0.0	0	262	1,280	0.5	1,018-
INSURANCE	170	170	0.9	0	1,950	2,844	0.9	90-
TRAILER ALLOWANCE	0	11	0.0	11	0	880	0.3	880-
OPERATORS LICENCE	0	0	0.0	0	0	0	0.0	0
OTHER TRANSPORTATION	0	25	0.1	25-	0	840	0.4	840-
TOTAL TRANSPORTATION	\$ 605	\$ 854	4.7	\$ 157-	\$ 7,667	\$ 17,712	8.3	\$ 10,045-
OTHER OPERATING EXPENSES:								
LICENSE FEES	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 43	0.0	\$ 43-
PROFESSIONAL SERVICE	0	0	0.0	0	0	0	0.0	0
PROD. DEVELOPMENT	100	0	0.0	100	1,100	130	0.0	970
CONSULTATION	0	1,115	6.1	1,115-	0	0,179	3.8	0,179-
EMPLOYEE RECRUITMENT	10	35	0.3	45-	110	354	0.1	244-
OTHER OPERATING EXP	0	0	0.0	0	0	53	0.0	53-
TOTAL OTHER OPERATING EXPENSES	\$ 110	\$ 1,170	6.4	\$ 1,060-	\$ 1,210	\$ 0,759	4.1	\$ 7,549-
EQUIPMENT AND FURNITURE:								
APPLIANCES	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 100	0.0	\$ 100-
DRAPES & CURTAINS	0	0	0.0	0	0	0	0.0	0
FIRE SAFETY EQUIPMENT	0	0	0.0	0	0	65	0.0	65-
FURNISHINGS	25	0	0.0	25	275	0	0.0	275
KITCHENWARE	0	0	0.0	0	0	0	0.0	0
LINENS	0	0	0.0	0	0	0	0.0	0
OFFICE EQUIPMENT	0	0	0.0	0	0	0	0.0	0
TOTAL EQUIPMENT AND FURNITURE REPLACEMENT	\$ 25	\$ 0	0.0	\$ 25	\$ 275	\$ 165	0.0	\$ 110
RESIDENT ALLOWANCE	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
RESIDENT MEDICAL	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
TOTAL OPERATING EXPENSES	\$ 18,544	\$ 18,017	100.0	\$ 527	\$ 203,984	\$ 212,259	100.0	\$ 8,275-
ADMINISTRATION	2,091	720	4.0	1,371-	23,001	720	3.3	22,281
REVENUE IN EXCESS OF EXPENSES (EXPENSES IN EXCESS OF REVENUE)	\$ 0	\$ 3,627	20.1	\$ 3,627-	\$ 0	\$ 14,281	6.7	\$ 14,281-

:6 26. 91 707

June 5, 92 - Mark's Bank

Doug Eickler Financial Statement

INCOME-

- ① SSI - AVERAGES BETWEEN 400.00 TO 490 A MONTH Depending ON WORK INCOME.
- ② WINDS - AVERAGES ABOUT 75.00 TO 100 DOLLARS A MONTH
- ③ TOTAL MONTHLY INCOME AVERAGES BETWEEN 400 + 500 HUNDRED DOLLARS.

MONTHLY EXPENSES

- ① BOARD + CARE - 340.00 A MONTH - Doug pays
- ② LAUNDRY - 5 DOLLARS A WEEK - ASI pays
- ③ GROCERYS - 50 DOLLARS A WEEK ASI pays
- ④ Spending Money - 5-15 DOLLARS A WEEK - Doug pays
- ⑤ DOGS EXPENSES Run Around 400.00 DOLLARS A MONTH, IF EXTRA MONEY IS LEFT OVER IT GOES INTO CHECKING FOR PLANNING A TRIP. BIRTHDAY - CHRISTMAS PRESENTS, OR MONEY TO BUY CLOTHES WITH

Alternative Services of Oregon, Inc.
Expenses for Doug Michler
6/92

Direct Costs

Rent	\$395.00	
Electricity	19.00	
Telephone	26.13	- Office Allocation
Other Utility Expense	20.00	
Consultations	<u>418.67</u>	

\$ 878.80

Allocated Costs

Emerging Call Systems	\$ 5.46
Insurance	18.80
•Other General Maintenance	0.00
Activity Materials	14.81
Food	158.04
Household Goods	49.95
Office Supplies	18.30
Transportation	132.71
Employee Recruitment	58.64
Professional Services	<u>40.67</u>

497.38

Total Costs

\$1376.18

At meeting with ASI executives it was stated that records were in the book for Doug's expenditures prior to 6/9/92. Reported that Exec Director for ASI of Oregon, Randall Wadlow, removed records from Doug's file prior to 6/11/92.

Adm. 1.7 11/92 Exec Dir Overkeeper FTR Randall 7.00 Wadlow
3 1/2 { 1.00 Betty Williams
50 21 26.21 908
1 1/2 sec

ALTERNATIVE SERVICES-OREGON, INC.
LUNA DRIVE

STATEMENT OF REVENUE AND EXPENSES COMPARED TO BUDGET
FOR THE PERIOD FROM JUNE 1, 1992 TO JUNE 30, 1992

	CURRENT QUARTER				YEAR TO DATE			
	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE
OPERATING REVENUE:								
PER DIEN REVENUE:								
CONTRACT REVENUE-9050	\$ 18,327	\$ 18,327	96.3	\$ 0	\$ 219,924	\$ 219,923	94.7	\$ 1
ROOM/BOARD	1,674	1,783	8.9	25-	20,136	20,943	8.6	93
RENT SUBSIDY	630	630	3.3	0	7,560	7,560	3.2	0
OTHER	0	0	0.0	0	0	0	0.0	0
OTHER	0	0	0.0	0	0	0	0.0	0
OTHER	0	0	0.0	0	0	0	0.0	0
OTHER	0	0	0.0	0	0	0	0.0	0
FOOD STANDS	0	0	0.0	0	0	395	0.1	395-
TOTAL PER DIEN REVENUE	\$ 20,635	\$ 20,660	100.5	\$ 25-	\$ 247,620	\$ 247,921	100.8	\$ 301-
OTHER OPERATING REVENUE:								
JOB TRAIN/WAGE SUBS	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
CONTRACT REVENUE	0	0	0.0	0	0	0	0.0	0
DIVERSION REVENUE	0	0	0.0	0	0	0	0.0	0
MEDICAL REIMBURSEMENT	0	0	0.0	0	0	0	0.0	0
OTHER STATE REVENUE	0	0	0.0	0	0	0	0.0	0
TOTAL OTHER OPERATING REVENUE	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
TOTAL OPERATING REVENUE	\$ 20,635	\$ 20,660	100.5	\$ 25-	\$ 247,620	\$ 247,921	100.8	\$ 301-
OPERATING EXPENSES:								
WAGES AND FRINGES:								
PROGRAM MANAGER	\$ 640	\$ 389	2.0	\$ 251	\$ 7,640	\$ 6,276	2.7	\$ 1,404
HOME HON/BIENN SPEC	1,974	1,454	7.6	524	23,736	22,494	5.6	1,242
DIRECT CARE	7,204	7,692	40.4	488-	87,400	94,050	40.5	6,650-
IN-SERVICE TRAINING	0	0	0.0	0	0	0	0.0	0
VACATION & SICK PAY	612	280	1.0	404	7,344	2,363	1.0	4,981
ONE-TO-ONE PAYROLL	0	0	0.0	0	0	0	0.0	0
CLINICAL	0	371	1.9	371-	0	644	0.2	604-
OTHER WAGES	0	0	0.0	0	0	18	0.0	18-
PENSION PLAN EXPENSE	0	0	0.0	0	0	0	0.0	0
PAYROLL TAXES	1,157	943	5.1	174	12,004	12,518	5.8	336
GROUP INSURANCE	1,080	480	2.2	660	13,056	4,543	1.9	5,513
WORKERS COMPENSATION	1,157	504	2.0	573	13,004	12,025	5.5	1,059
TOTAL WAGES AND FRINGES	\$ 12,916	\$ 12,109	63.6	\$ 1,607	\$ 164,992	\$ 156,001	67.2	\$ 18,191

ALTERNATIVE SERVICES-OREGON, INC.
LAWN DRIVE

STATEMENT OF REVENUE AND EXPENSES COMPARED TO BUDGET
FOR THE PERIOD FROM JUNE 1, 1992 TO JUNE 30, 1992

	CURRENT QUARTER				YEAR TO DATE			
	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE
SHELTER:								
RENT	\$ 1,668	\$ 1,720	9.8	\$ 148	\$ 20,328	\$ 20,943	9.8	\$ 1,337
BUILDING DEPRECIATION	0	0	0.0	0	0	0	0.0	0
PROPERTY TAX	0	0	0.0	0	0	0	0.0	0
TOTAL SHELTER	\$ 1,668	\$ 1,720	9.8	\$ 148	\$ 20,328	\$ 20,943	9.8	\$ 1,337
UTILITIES:								
ELECTRICITY	\$ 217	\$ 120	0.5	\$ 97	\$ 2,584	\$ 2,622	1.1	\$ 18-
HEAT	0	0	0.0	0	0	0	0.0	0-
TELEPHONE	380	190	1.0	110	3,600	3,195	1.3	405
WATER AND SEWAGE	0	0	0.0	0	0	0	0.0	0
SANITATION	0	0	0.0	0	0	25	0.0	25-
SEPTIC SERVICE	0	0	0.0	0	0	0	0.0	0
OTHER UTILITY EXPENSES	58	92	0.4	42-	600	942	0.4	342-
EMERGENCY CALL SYSTEM	34	27	0.1	7	400	294	0.1	114
TOTAL UTILITIES	\$ 681	\$ 429	2.2	\$ 179	\$ 7,212	\$ 7,084	3.0	\$ 128
INSURANCE	\$ 218	\$ 94	0.4	\$ 116	\$ 2,520	\$ 1,056	0.4	\$ 1,464
ROUTINE MAINTENANCE:								
LAWN CARE & SNOW REMOVAL	\$ 0	\$ 0	0.0	\$ 0	\$ 2	\$ 9	0.0	\$ 9-
PEST CONTROL	0	0	0.0	0	0	0	0.0	0
OTHER GENERAL MAINTENANCE	50	0	0.0	50	600	1,057	0.4	457-
TOTAL ROUTINE MAINTENANCE	\$ 50	\$ 0	0.0	\$ 50	\$ 600	\$ 1,066	0.4	\$ 466-
MAJOR REPAIRS	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
ACTIVITY MATERIALS	\$ 75	\$ 74	0.3	\$ 1	\$ 900	\$ 1,020	0.4	\$ 120-
CONSUMABLE SUPPLIES:								
FOOD	\$ 866	\$ 790	4.1	\$ 76	\$ 10,392	\$ 10,193	4.3	\$ 199
HOUSEHOLD GOODS	99	235	1.2	136-	1,188	3,234	1.3	2,046-
CLOTHING	0	0	0.0	0	0	0	0.0	0
OFFICE SUPPLIES	25	95	0.5	70-	300	362	0.1	62-
NON-PRESCRIPTION	0	0	0.0	0	0	0	0.0	0
OTHER	10	13	0.0	3-	120	131	0.2	11-
TOTAL CONSUMABLE SUPPLIES	\$ 1,000	\$ 1,133	5.9	\$ 133-	\$ 12,000	\$ 13,920	6.0	\$ 1,920-

ALTERNATIVE SERVICES-OREGON, INC.
LAVA DRIVE

STATEMENT OF REVENUE AND EXPENSES COMPARED TO BUDGET
FOR THE PERIOD FROM JUNE 1, 1992 TO JUNE 30, 1992

	CURRENT QUARTER				YEAR TO DATE			
	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE	BUDGET	ACTUAL	% OF TOTAL OPERATING EXPENSES	VARIANCE
TRANSPORTATION:								
VEHICLE LEASE	\$ 325	\$ 340	1.7	\$ 14-	\$ 3,912	\$ 10,950	4.7	\$ 7,038-
VEHICLE DEPRECIATION	0	0	0.0	0	0	0	0.0	0
FUEL	110	143	0.7	35-	1,390	2,343	1.0	1,009-
MAINTENANCE	33	0	0.0	33	296	1,200	0.5	812-
INSURANCE	170	170	0.9	0	2,135	2,225	0.9	90-
MILEAGE ALLOWANCE	50	71	0.3	21-	600	872	0.3	272-
OPERATORS LICENSE	0	0	0.0	0	0	0	0.0	0
OTHER TRANSPORTATION	0	0	0.0	0	0	840	0.3	840-
TOTAL TRANSPORTATION	\$ 697	\$ 734	3.8	\$ 37-	\$ 8,364	\$ 10,443	7.9	\$ 10,081-
OTHER OPERATING EXPENSES:								
LICENSE FEES	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 43	0.0	\$ 43-
PROFESSIONAL SERVICE	0	200	1.0	200-	0	800	0.0	200-
PROP DEVELOPMENT	100	3	0.0	97	1,200	133	0.0	1,067
CONSULTATION	0	2,070	10.0	2,070-	0	10,240	4.4	10,240-
EMPLOYEE RECRUITMENT	10	253	1.0	263-	100	647	0.2	327-
OTHER OPERATING EXP	0	0	0.0	0	0	52	0.0	52-
TOTAL OTHER OPERATING EXPENSES	\$ 110	\$ 2,566	13.4	\$ 2,456-	\$ 1,300	\$ 11,324	4.8	\$ 10,004-
EQUIPMENT AND FURNITURE:								
APPLIANCES	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 100	0.0	\$ 100-
DRAPES & CURTAINS	0	0	0.0	0	0	0	0.0	0
FIRE SAFETY EQUIPMENT	0	0	0.0	0	0	65	0.0	65-
FURNISHINGS	25	110	0.5	85-	300	110	0.0	190
KITCHENWARE	0	0	0.0	0	0	0	0.0	0
LINENS	0	0	0.0	0	0	0	0.0	0
OFFICE EQUIPMENT	0	0	0.0	0	0	0	0.0	0
TOTAL EQUIPMENT AND FURNITURE REPLACEMENT	\$ 25	\$ 110	0.5	\$ 85-	\$ 300	\$ 275	0.1	\$ 25
RESIDENT ALLOWANCE	\$ 0	\$ 0	0.0	\$ 0	\$ 0	\$ 0	0.0	\$ 0
RESIDENT MEDICAL	\$ 0	\$ 62	0.3	\$ 62-	\$ 0	\$ 62	0.0	\$ 62-
TOTAL OPERATING EXPENSES	\$ 10,544	\$ 19,831	100.0	\$ 487-	\$ 222,520	\$ 232,836	100.0	\$ 9,503-
ADMINISTRATION	2,091	2,091	10.0	0	25,092	25,092	10.0	0
REVENUE IN EXCESS OF EXPENSES EXPENSES IN EXCESS								
					\$ 9,287-		3.9	\$ 9,287

**Marlene J. Carson
8325 S. W. 191st
Aloha, Oregon 97007
503-591-1184**

August 11, 1992

Office of the Executive Director
Alternative Services of Oregon, Inc.
18965 S. W. 84th
Tualatin, Oregon 97062

RE: Grievance

Dear Executive Director:

This letter is being filed as grievance regarding an incident which occurred between your staff person Rob S. and my son Douglas Eichler on August 6, 1992. I feel the incident was handled very badly and the excuse that the staff person had worked 70 hours without a day off, in my opinion, is not a good one.

When my son was taken to the doctor at my request, the doctor was not told the reason for the visit, only that Doug had fallen into some shrubbery. At this time it appears that this incident might be classified as abusive. It is my intent for writing this grievance to have it placed in the client personnel file as well as that of the staff member.

Sincerely,

Marlene J. Carson

Marlene J. Carson

cc: Ms. Sue Stoner, State of Oregon
Ms. Karen Curry, State of Oregon
Ms. Lori Thompson, Behaviorist Consultant
Mr. Brad Johesson, Attorney at Law
Ms. Annie Veegas, Oregon Advocacy Center

BARRY M. MALETZKY, M.D., P.C.
PSYCHIATRIST
8332 S.E. 13TH AVE.
PORTLAND, OREGON 97202
PHONE: 503-238-5580
FAX: 503-238-0210

August 18, 1992

Marlene Carson
 8325 SW 191st
 Aloha, Oregon 97007

Re: Doug Elchler

Dear Ms. Carson:

After reviewing Doug's situation, I am making the recommendation that he be placed in a group home placement where adequate supervision and structure can be provided. I am very worried that Doug is at risk while being at large in the community because he has demonstrated an incapacity to follow through with requests from other people, an inability to monitor and control his own behavior, frequent runaways, and illegal behaviors. The greatest risk is posed to Doug himself. Because of these behaviors, I believe he will come to some harm.

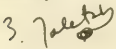
I do not believe that the present level of supervision is adequate for Doug. I believe that in a group home setting, where he can be constantly observed, he can prove to others whether or not he can be trusted again to be at liberty. In addition, under such a setting new medications can be tried.

However, for now I believe that the medications tried thus far, including Lithium, Mellaril, and Prozac, have been ineffective. I have asked that Prozac be discontinued so that we can see what his behavior is like off medications. New medicines can be tried but only within a safe setting.

I am entrusting you to convey the above information and recommendations to Developmental Disabilities Division and Alternative Services, and ultimately to Susan Stoner of Mental Health Developmental Disabilities.

I hope this information proves helpful, but please let me know if I can provide any further information or assistance.

Sincerely,



Barry M. Maletzky, M.D.
 Professor of Clinical Psychiatry
 Oregon Health Sciences University

BMM:mfn

W1102001- 3

ADVICE OF UNPAID DEPOSITED ITEMS
FOR ACCOUNT NO. 0930007042- 0

PAGE 1 OF 1
11-02-1992

THE FOLLOWING ITEM HAS BEEN RETURNED

We are charging your account \$404.45 for one item returned unpaid as listed below and a \$2.00 return item handling fee.

DRAWN BY	ON	REASON	AMOUNT
DOUGLAS EICHLER	24-22	2 SIGNERS REQUIRED	404.45
TO: MARLENE J CARSON OR RICHARD S CARSON 8325 SW 191ST ALPHA OR		FROM: FAR WEST FEDERAL SAVINGS BANK RETAIL OPERATIONS P O BOX 40149 PORTLAND, OR 97240 (503) 224-4444	
	97007-6025		

DOUGLAS R. EICHLER
18965 SW 84TH AVE
TUALATIN, OR 97061

Return Not Paid
Endorsement
Signature
Unavailable Funds

PAY TO THE ORDER OF Marlene J Carson \$ 404.45

Date 10-27-92

Other four hundred four dollars and 45/100 DOLLARS

U.S. BANK 1-800-438-5663
UNITED STATES NATIONAL BANK OF OREGON

MEMO check account

315

3123000220: 133 082 89 0315 000040445

W1102001- 3

ADVICE OF UNPAID DEPOSITED ITEMS
FOR ACCOUNT NO. 0930007042- 0

PAGE 1 OF 1
11-02-1992

THE FOLLOWING ITEM HAS BEEN RETURNED

We are charging your account \$404.45 for one item returned unpaid as listed below and a \$2.00 return item handling fee.

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TO: MARLENE J CARSON OR RICHARD S CARSON 8325 SW 191ST ALPHA OR		FROM: FAR WEST FEDERAL SAVINGS BANK RETAIL OPERATIONS P O BOX 40149 PORTLAND, OR 97240 (503) 224-4444	
	97007-6025		

Fairview Parents Assoc.
Parents Meeting March 27, 93

Previous Agenda from January - 1993

*Red
Kassins
for STERB*

Areas of concern:

1. Board Members and interested Association members moving out into the community for Boards and Commissions
2. We need more clarification of impending legislation and proposed movement by MHD
3. GAPS - pervasive problems with organization and client involvement/advocacy-need to share gathered information etc.
4. AIM PROJECT - Unresponsive to families of clients and advocates in need-to-know areas/ nonaggressive advocacy toward many clients - high turnover/ public funds, vrs. private knowledge excluding so-called "confidentiality"
5. State (MHD) "investigations" seriously flawed in methodology and professionalism. No remedial action to correct apparent by State even when critical, pervasive problems are uncovered State-wide.
6. Need to promote and administer a significant screen-out of seriously damaging and incompetent staff in providerships and agencies level
7. On-going problems with Alternative Services, Inc. - i.e. incompetence, instigation of clients, legal threats against advocates, unprofessional attitudes, suspicious dealings etc. Current status of our advocates re: federal and state government, etc.
8. Re: Fairview Parent/Guardian Association (which has expanded advocacy to community) - redefinition of goals. Identification of targeted areas of concern and ongoing advocacy. Assignment of areas of on-going need for advocacy and aggressiveness etc.
9. NEED FOR SHARP FOCUS ON HOW, WHEN, WHERE WE ARE GOING TO ADVOCATE AGGRESSIVELY. Need for a cogent system in place.
10. Question to consider - How far in our advocacy are we willing to go? (Consider issues of "legal" actions, pressures, threats, intimidation, character assassination etc. of our members, families, clients in the system)
11. Follow up information - M.A. Ford's subcommittee/Toews response - possible future action etc.
12. WILL WE REPLY TO JAMES TOEWS REPORT TO FORD'S COMMITTEE AND IN WHAT FASHION?
13. Discuss problems of "to-the-state line-only" background investigation of prospective provider employees especially those who will deal with and interact with our family members.

ADDITION CONCERNS SINCE LAST MEETING.....

LANE
POWELL
SPEARS
LUBERSKY

January 15, 1993

Law Offices

520 S.W.
Yamhill Street
Suite 800
Portland, OR
97204-1383

(503) 226-6151

Telex:
269029-SPRS-UR
Facsimile:
(503) 224-0388

A Partnership
Including
Professional
Corporations

Ms. Marlene Carson
8325 S.W. 191st Street
Aloha, OR 97007

Re: Anita Ellis v. Alternative Services
Clackamas County Circuit Court Case No. 92-9-32
Our File No. 701750-2

Dear Ms. Carson:

I represent Alternative Services-Oregon, Inc. ("ASI"). ASI has an obligation to protect its clients from abuse and exploitation. Because of your past exploitative conduct, including your recent attempt to obtain and disseminate confidential client records and your intrusion upon the privacy rights of our clients, you are no longer permitted on any premises owned, leased or managed by ASI without prior written permission of ASI.

If you need to enter upon ASI premises, please direct the request to me. If you attempt to enter ASI property, you will be asked to leave, and if you refuse to leave, we will request that you be arrested for trespass.

Very truly yours,

Robert C. Dougherty
Robert C. Dougherty

Anchorage, AK
Los Angeles, CA
Mount Vernon, WA
Olympia, WA
Portland, OR
Seattle, WA
London, England
Tokyo, Japan

Marlene J. Carson
8325 S. W. 191st
Aloha, Oregon 97007
503-591-1184

February 11, 1993

To Whom It May Concern:

The accompanying letters level against me accusations pertaining to my character, my personal ethics and conduct, and certain events both past and present in my life. The gross misrepresentation and patently false nature of the content of the letters and their self-serving interest indicates poor investigation on the part of parties making the accusations.

Because I was repeatedly denied access to the charges of specifics against me, which led to letter number 1 dated January 15, 1993, and because letter number 2, circulated without my knowledge to people with whom I have never had contact, I submit to you my response with multiple copies to those listed at closure. Every fact in this letter comes from an extensive diary kept by me on a daily basis since my early involvement with Alternative Services Incorporated of Oregon and could, if need be, sworn to in a court of law.

Pertaining to the letter addressed to S. Harris, a copy of which was not sent to me, I now address each paragraph by number affixed on the a copy of the original document.

Paragraph number 1

No comment. This is self-explanatory.

Paragraph number 2

Leeroy Synoground, age 28 and Joe Ledbetter, age 22, live in their own private apartment located in a multi-unit apartment complex. I have never visited them, individually or collectively, on an unannounced basis and without prior arrangement made between those parties well in advance of my arrival as their friend. I was invited to participate on the ISP team by Joe and Leroy, who have been referred to in the past as their "own legal guardians." In Joe's case, all parties in attendance agreed to his constructed ISP program. I do not remember witnessing any adverse reaction to my presence by the assembled "team", and I purposely maintained a somewhat low key

February 11, 1993

Page 2

participation profile. The bulk of the agreed upon Program Plan for Joe was not subsequently run according to the "team" agreement. For example, Joe then, as he does now, often sleeps much of his day away, rising many times in the afternoon. I share the opinion of many, that Joe needs to be gainfully employed and he can not do so if he is allowed to spend his life bedridden. It is my understanding that large sums of money have been invested by taxpayers for the purpose of providing employment services. Joe Ledbetter believes, and I concur, that he has no stability in his life and does not actively participate in previously identified personal goals. He is poorly motivated by staff who have repeatedly used vulgar and inappropriate language in his presence to and about me and whose personal habits precipitated the eviction notice to staff at the ASI Lava Drive facility. ASI staff intimidated clients by indicating that it was they, the clients, who were being evicted. In fact, it was the conduct of ASI employees who led to their notice of eviction. Therefore, this eviction of the office apartment at the ASI Lava Drive facility appears to be a direct reflection upon the quality of staff hired by Alternative Services, Inc.

Paragraph number 3

I did not request release of Joe Ledbetter's records for my inspection as the letter so indicates. Joe Ledbetter and Leeroy Synoground requested an appointment by telephone with attorney, Steven Lawrence in order to, as they expressed it, "help clear Anita Ellis's name" of certain charges being made by ASI and others. After the appointment had been made by them, both young men called Mr. Briethaupt of the Fairview Parents Association and me and asked us to attend the meeting in Joe's apartment. Joe insisted vehemently that I cancel a previously made commitment in order to attend. "It's real important", he said, so we both attended. Both men had repeatedly talked of having this meeting, so I was aware of their intense interest in their former Program Manager and "good friend". They had debated the mechanics of instigating such a meeting for several months. Before Mr. Lawrence arrived, Joe approached a female staff person and asked that Toni, Joe's female roommate, be permitted to go to Leroy's apartment -- in which she habitually spends time during the day. Joe always graciously leaves his apartment during Toni's private sessions with her psychologist so he felt this to be fair, as did she.

Mr. Lawrence and Joe were discussing the alleged "forging of checks" by a former ASI manager when specific dates were asked by Mr. Lawrence to be identified. Joe was not able to recall those dates, but said "we can look in my financial books". Joe immediately left his apartment to go to the ASI Office in the complex where his personal financial records were kept. We waited about 10 or so minutes and Joe returned without his financial book. He said, "they won't give it to me", which is hard to understand given the fact that they had stated that he was his own guardian. About that time, Leeroy appeared at Joe's apartment from his own meeting somewhere on the

February 11, 1993

Page 3

premises. Leeroy was disheveled, in poor physical shape, mumbling in repetitive manner, walking in a staggering gait with very apparent poor depth perception. He was pale and ill-looking, and focusing on me with glazed eyes. Mr. Lawrence also noted that something was dramatically wrong with Leeroy. Since I had known Leeroy for at least six years, both at his placement at Fairview Training Center and as a former roommate of my son, Doug Eichler, for four months, I was appalled and concerned at what appeared to be a rapid disintegration of his physical and mental health. I had never seen him in such a condition before.

ASI staff continuously attempted to enter Joe's apartment as the five of us tried to talk. Those present were Leeroy, Joe, Mr. Lawrence, Mr. Breithaupt and me. Joe, frustrated by his lack of privacy and staff violation of his civil rights to have a conversation with guests, got up and locked the door to his apartment. ASI staff employees promptly let themselves in Joe's apartment with a passkey. Leeroy suggested that we all adjourn and go over to the Oregon Advocacy Center, which is Joe's "second home". He has been there on his own frequently talking with OAC staffers. Mr. Lawrence had to leave to finish his day's work and the rest of us proceeded to the OAC office where we talked to Ms. Suzy Harris. During the outing, Leeroy uncharacteristically had to be physically assisted to ambulate because of mobility and instability problems.

It should be noted specifically that my involvement for the first time with Mr. Breithaupt was April 5, 1992 when I was introduced to him. I have not had a "long involvement" with this knowledgeable gentlemen as implied in the letter of unfounded accusation and, in fact, only met him by chance following a discussion of my frustration with ASI services provided my son Douglas with a co-worker who disclosed to me that she had a retarded child as well.

I am in possession of all of the television series tapes regarding Alternative Services, Incorporated of Oregon presented by both Eric Mason of Channel 6 and other reporters. At no time on those tapes or elsewhere was any personal information about any client dispersed by me to the reporter or any other person. I was, however, along with my son, Doug, highlighted regarding our own specific situation with the provider agency ASI. This was done with mutual permission and co-operation.

Joe Ledbetter has repeatedly asked me, as his advocate and friend, to be his "guardian" so that he may access his own records and know what is in them. I told him that we must both be considerate of his mother who has not been known to take an active part in his life. He asked me to sign a "release of information" form to help him understand his personal files and to assist him in getting control of his life. Joe Ledbetter can neither read nor write. Given the alleged theft of assets of clients, I thought that this was important.

February 11, 1993

Page 4

ASI requested a meeting because of Joe's desire to have information about him released to me was, according to them, not good enough. This meeting lasted three hours and conclusions were drawn. It was stated that I would have to be "voted upon" by voice vote by a group comprised of one Case Worker, one ASI participant, one OAC representative and Joe. The ground rules seem to be constructed or amended as we go along in order to fit certain needs. A 30 day extension was mandated by the committee. Somewhere in this scenario a "competency test" to determine Joe's ability to be "his own guardian" was discussed. To this day, no further information has been available to Joe, to Mr. Lawrence, or to me as to just how ASI views one of its more vocal clients. It appears to me to be a violation of Joe Ledbetter's civil rights not to be advised whether he is "competent to be his own guardian" after having been told for many ears that this will be his status at age of emancipation. That not one, including legal counsel, had defended his right to know his status is reprehensible and undefensible.

Contrary to statements made in the letter by ASI legal counsel, Joe and Leeroy, without assistance from anyone, called Eric Mason, Channel 6 investigative reporter and this has been confirmed by them. They knew Mr. Mason was preparing a series on providers - ASI in particular, and upon the impact of community placement resulting from downsizing of the Fairview Training Center facility.

Paragraph number 4

Douglas Eichler, my son, was moved to ASI in June of 1990. I had no knowledge of the agency prior to that time. Doug lived at Fairview Training Center at several different cottages. It is common knowledge at the Center and it should be in their records, which are now probably located in their Archives since his transition, that my husband and I, as co-guardians, have been staunch advocates for appropriate community placement for our son and others for whom this way of life is suitable.

Doug's two prior community placements before ASI, one negotiated by Pat Chaney, current Executive Director for ASI, were failures. His experience included a hotel in downtown Portland infested with roaches and whose residents were from the streets and at a group home where clients were of a very low level of ability. He stated many times that he did not belong there. To our mutual disappointment, Doug returned to Fairview Training Center as a safety net from two extraordinarily unhappy placements. This sad history in no way reflects upon or has ever reflected upon my aversion to either Fairview or the community programs. To say that I am obsessed "to close down programs" in the community is a perversion of information which the author of the letter claims to be privy. While I am now and have always been an advocate of well-run, competent providers, I have personally experienced, with others for whom I advocate, some of the most destructive placements which have nearly destroyed the lives of the clients of their families.

February 11, 1993

Page 5

The quote "see ASI closed down" was taken completely out of context from a meeting to which Mr. James Toews of the State of Oregon and Annie Villagas from the OAC, will attest. It is heresy and a twisted distortion of the bulk of the extended conversation in Mr. Toews office -- closed to all except for Mr. Toews, Ms. Villagas and my husband and me. The author of the letter was not in attendance at that meeting but makes statements of fact that he would like one to believe he was there.

In rebuttal to accusations of the author of the enclosed letter, which state that "exploiting clients" and "abusing staff", I have barely tolerated frequent abusive language from staff and have been threatened with violence and incarceration by lower level staff for visiting Joe. I can prove this statement because I have numerous phone messages where this language may be heard. One such example, where we returned Joe to his apartment as promised on a timely and prompt basis, we had to struggle to awake a staff person who was lying on a sofa and who appeared to be under the influence of something. She finally woke up and cursed at us and Joe in a violent manner.

My unblemished record of high personal ethics throughout my personal and working life precludes the exploitation of any individual, at any time, and at any level.

With reference to Ms. Stoner's, of the State of Oregon, comments that I would use "Joe's records for clearing Anita Ellis's name" is simply not accurate. This was not my comment but one made by Joe Ledbetter as previously described. Again, if one is to call upon Ms. Stoner to testify in a court of law, they will discover how inaccurate this statement is.

Paragraph number 5

I view my advocacy and friendship for Joe as a completely separate issue from Alternative Services, Incorporated. Joe and Leeroy have always expressed a sincere desire to help Ms. Anita Ellis in clearing her name, her professional reputation and to restore her standing in the mental health community.

Moreover, it is unclear to them as clients and to us, as advocates, as to whether full compensation of alleged stolen funds and property, which has been reportedly documented, has been made by the insurance company and/or service provider ASI. Any taxpayer should be concerned with the use of public funds especially concerned where possibilities of theft and fraud are involved. I wondered if this impacted the fact that a check written to me by an ASI staff person for expenditures that I made on their behalf in order to help them out of a problem area of concern and which subsequently bounced was caused by a reported theft of assets in October of 1992. I am concerned if similar events have occurred with other clients.

February 11, 1993

Page 6

Paragraph number 6

I have actively solicited Joe's mother, Linda Ledbetter, to become involved in Joe's life in several personal contacts. She has said she "would try to take more interest in her son's life" but it appears that she has chosen not to exercise this right to any significant degree. My husband and I drove to the Oregon coast in order to instill the fact that Joe desired to have her at his ISP meeting at ASI. She indicated that she would try to be there but for reasons unknown to us, never arrived.

GAPS apparently believed me to be eminently qualified to be a paid guardian to the other agency clients and hired me in the Fall of 1992 following a formal application and interview process. Because of pressures brought to bear upon the agency regarding past association with Anita Ellis, who was my son's Program Manager, and my involvement with Joe and Leroy at Alternative Services, Inc., my employment was quickly terminated after three and one half days. Correlate this with a written letter by James Toews, an Administrator of the State of Oregon Mental Health Division, in which he stated his philosophy that strong advocates for the retarded are to be regarded as a program strength. Apparently words are one thing while actions are another.

I serve as Vice President for Community Placement Advocacy for families and clients who have left Fairview Training Center during Community Integration Placement (CIP 1 and CIP 2) programs with the Fairview Parents/Guardian Association, who have expanded their oversight to extend beyond those residing at the institution. In that capacity, I have contact with clients and families all across the State of Oregon, in addition to my advocacy for former FTC residents, Joe Ledbetter and Leeroy Synoground. My sole interest in their lives, and especially Joe's at his request, is to be supportive of his dreams of being the best he can be in a stable and respected agency provider environment. If as much time were expended helping Joe to achieve his program objectives as has been directed at expunging me and my husband from his life, Joe would be a very contented young man.

Paragraph number 7

Mr. Doherty, author of the enclosed letter, is repeating himself. If he were to put himself in the shoes of a client, would he or any member of his family want to have all parties excluded from his life despite protests to the contrary, and to be solely at the mercy of a corporation paid well to provided services at only a basic level to maintain life? To be alone without someone who cares about you and who you are as a person is a frightening nightmare without end.

Paragraph number 8

February 11, 1993

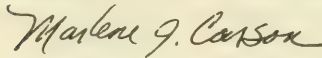
Page 7

I suggest that one consider information provided in this letter of response in light of any proposed meeting with the author of the attachments.

The blatant and appalling misuse of "professional muscle" by those who have attempted to harass and intimidate me and my family and those with whom I have consulted has revealed the depth of ineptness which is now being displayed by Alternative Services, Inc. of Oregon, it's legal counsel, and all those persons assisting them in this unprofessional behavior.

The avenue the author of the enclosed letter takes is a dangerous and foolish route. It would be very wise of him to review his source of information and direction.

Sincerely,



Marlene J. Carson

cc: Mr. Bob Joondeph, OAC
 Ms. Suzy Harris, OAC
 Ms. Annie Villegas, OAC
 Mr. Steven Lawrence, Esq.
 Representative Mary Alice Ford, State of Oregon
 Mr. Kevin Concannon, State of Oregon
 Mr. James Toews, State of Oregon
 Ms. Sue Stoner, State of Oregon
 Congressman Ron Wyden, U. S. House of Representatives
 Mr. Leeroy Synoground, ASI
 Mr. Joseph E. Ledbetter, ASI
 Board of Directors, Fairview Training Center
 Ms. Linda Ledbetter
 Ms. Sara Jane Owens, GAPS
 Ms. Anita Ellis
 Ms. Pat Chaney, ASI
 Mr. Eric Mason, KOIN T.V. Channel 6
 Dr. B. Stabler
 Dr. Jack Vandenberg
 Mr. and Mrs. Bud Breithaupt
 Mr. and Mrs. Robert Cochran

LANE
POWELL
SPEARS
LUBERSKY

*Letter
#1
mp*

January 15, 1993

Law Offices

520 S.W.
Yamhill Street
Suite 800
Portland, OR
97204 1383

(503) 226-6151

Telex

269029-SPRS UR

Facsimile:

(503) 224-0388

A Partnership

Including

Professional

Corporations

Ms. Marlene Carson
8325 S.W. 191st Street
Aloha, OR 97007

Re: Anita Ellis v. Alternative Services
Clackamas County Circuit Court Case No. 92-9-32
Our File No. 701750-2

Dear Ms. Carson:

I represent Alternative Services-Oregon, Inc. ("ASI"). ASI has an obligation to protect its clients from abuse and exploitation. Because of your past exploitative conduct, including your recent attempt to obtain and disseminate confidential client records and your intrusion upon the privacy rights of our clients, you are no longer permitted on any premises owned, leased or managed by ASI without prior written permission of ASI.

If you need to enter upon ASI premises, please direct the request to me. If you attempt to enter ASI property, you will be asked to leave, and if you refuse to leave, we will request that you be arrested for trespass.

Very truly yours,

Robert C. Dougherty
Robert C. Dougherty

Anchorage, AK

Los Angeles, CA

Mount Vernon, WA

Olympia, WA

Portland, OR

Seattle, WA

London, England

Tokyo, Japan

LANE
POWELL
SPEARS
LUBERSKY

*Letter #2
mjc*

recd. Feb 6, 93

February 1, 1993

FEB. 02 1993

VIA FACSIMILE/ORIGINAL by U.S. MAIL

Law Offices

520 S W
Yamhill Street
Suite 800
Portland, OR
97204-1383

(503) 226-6151

Telex
269029-SPRS-UR
Facsimile
(503) 224-0388

A Partnership
Including
Professional
Corporations

Suzy Harris, Esq.
Oregon Advocacy Center
625 Board of Trade Building
310 S.W. Fourth Avenue
Portland, OR 97204-2309

Re: Alternative Services-Oregon, Inc.
Our File No. 701750-2

Dear Ms. Harris:

I tried to reach you last week a couple of times without success. I received a copy of your letter to Mr. Toews, and more recently, your letter to me. As I indicated in the telephone messages that I left, I would like you to contact me as soon as possible.

We investigated this matter very thoroughly before very narrowly restricting Ms. Carson's right to come upon ASI premises without prior consent. We obtained professional medical opinions and discussed the matter with both Mental Health and the Department of Justice. Ms. Carson's disruption of the group home, her interference with other clients' rights, her constant deviation from decisions made by the ISP team (even those decisions in which she was involved, but in which the majority of the team members were adverse to her position) finally culminated in our decision to very narrowly restrict Ms. Carson's rights.

In this case, and in the future, I would appreciate it if you would give me a call to learn the basis for ASI's action before jumping to conclusions such as those reached in your letters to me and Mr. Toews. ASI's objection to producing Mr. Ledbetter's confidential documents to Mr. Lawrence, or to Ms. Carson (whose stated intention was to give them to Mr.

Anchorage, AK
Los Angeles, CA
Mount Vernon, WA
Olympia, WA
Portland, OR
Seattle, WA
London, England
Tokyo, Japan

Suzy Harris, Esq.
 February 1, 1993
 Page 2

Lawrence) was based solely upon our evaluation of our legal obligations to Mr. Ledbetter. Release of those documents would exonerate ASI, at least in part, from Ms. Ellis' claims. I had previously invited Mr. Lawrence to meet with me to discuss a workable solution to the confidentiality issue that would allow input from the case manager and/or ISP team for each client whose records are involved. Instead of responding to my request, or moving to compel production of documents (in which case I could invite input from the ISP team of the clients involved and at least bring the issue to the Court's attention), Mr. Lawrence, Mr. Breithaupt, and Ms. Carson isolated Joe in his apartment (demanding that his roommate leave -- which is also a violation of her rights), and asked Joe to go and get his confidential records. Before we decided to take the action against Ms. Carson, we asked for input from Mental Health and the Department of Justice, and obtained a professional medical opinion as to Joe's ability to comprehend what the release of documents could mean to him. As may you know, Ms. Ellis, Mr. Breithaupt and Ms. Carson obtained confidential (and somewhat embarrassing for the client) information about ASI clients which they later gave to a television station. Both Mental Health and the Department of Justice told us that they "would not support" our releasing a copy of confidential records which we reasonably knew would flow into the hands of Ms. Carson and Mr. Breithaupt until the ISP team had met and previously determined the client's ability to understand what the consent meant, and perhaps to suggest or impose additional safeguards on further dissemination of any records which they determined the client was competent to release. There are oftentimes items in a client's medical, program and finance records which could be very damaging to the client if spread across the 8:00 news.

cf. page
 You may also not know the long history Ms. Carson and Mr. Breithaupt have with ASI and the Mental Health Division. Ms. Carson has a long history of trying to disrupt and close down programs such as ASI because she would like to see the state return to an institutional format such as existed before the down scaling of Fairview. When she recently met with James Toews, the head of Oregon Mental Health, Mr. Toews asked Ms. Carson what it is she wanted to see changed or improved. Ms. Carson told Mr. Toews that she wanted to "see ASI closed down." Every person is entitled to their opinion, but Ms. Carson should take her concerns to the legislature, rather than harass ASI clients and staff. Unfortunately, Ms. Carson

Suzy Harris, Esq.
 February 1, 1993
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has chosen to use the tactic of simply exploiting ASI clients and abusing ASI staff as a means of trying to achieve her goals. You may also find it interesting that Ms. Carson told Sue Stoner of Mental Health that she asked for Joe's confidential records for the purpose of helping Mr. Lawrence to assist in "clearing Anita's name," and not for the purpose of helping Joe to understand his program or his rights.

(S) 744
 You also mentioned issues surrounding Joe's finance records. Anita Ellis, the person Ms. Carson supposedly was helping, was the former program manager for ASI when the finance issue arose. Ms. Ellis was the person at ASI with the direct responsibility to audit and protect Joe's finances during the period of time in which the alleged "Medicaid fraud" was occurring. The person directly involved, Brian Orr, was hired by, promoted by, supervised by, supposed to have been audited by, protected from termination by, and eventually fired along with, Ms. Ellis. At the very least, that puts Ms. Carson's and Mr. Lawrence's interests somewhat adverse to Joe. ASI, of course, returned Joe's money.

(S) 744
 ASI will facilitate any action in the best interest of Joe, or any other client. There may be, however, good faith disputes about what is best for a particular client. Joe's mother, for example, is not wholly supportive of Ms. Carson's relationship with Joe in that she does not believe that Ms. Carson should have unrestricted access to and control over all aspects of Joe's life. I would also remind you that ASI and Mental Health, which work together very well, are staffed by professionals, many of whom are the parents of developmentally disabled children. Ms. Carson has no professional training. I think that you will find that if you approach this issue from an unbiased standpoint, and fully complete your investigation of this matter, that Ms. Carson not only seriously misled you, but she is also the person who has caused the current problem for Joe. If you review the medical and program records, you will find that Joe has been more successful in his placement with ASI than in any other in which he has ever resided. His records will also show that his disability causes him to constantly vary from wanting to stay at ASI, to wanting to leave. His confusion is obviously enhanced when he feels pressure from those, such as Ms. Carson, who continually want to put him in the spotlight and use him to promote their own personal interests. It is not now, and never will be, our intention to discharge Joe or any

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other client from our program without the client's request. Each time that Joe previously requested to leave ASI, we notified his case manager. He then became very anxious, however, and wanted to know if ASI was "kicking him out."

Joe is certainly not the problem. ASI has enjoyed having Joe in its program and has the full ability to serve his needs. However, it appears that Marlene Carson's continued involvement and disruption of Joe's program does, perhaps, make this an irreparable situation -- not from our point of view, but from hers. Unfortunately for Joe, until Ms. Carson's control over every aspect of his life is limited, he will continue to have problems wherever he is placed.

I would again urge you to contact me as soon as possible. If you have an hour or so in the near future, I would be pleased to meet with you. I would hope, however, that you will reserve further judgment until we have spoken.

Very truly yours,

Robt C Dougherty
 Robert C. Dougherty

bc: Ms. Pat Chaney ✓
 Thomas G. D'Luge, Esq.
 Jill Goldsmith Dinse, Esq.
 George L. Kirklin, Esq.
 Ms. Robin H. Kuehnast
 Richard F. Liebman

March 7, 93
Monday

" My goal is to get ASI shut down; Not only in Oregon but in the whole USA. They are crooked people men" They stole a bunch of my money & other clients' money. We also heard they have done this in other states. I'm afraid when I leave the other clients will be treated bad. I wish they could be moved out of ASI like me Joe. Sometimes there is not enough food for us all. ~~They don't~~ The staff eat up our food & sometimes take it home with them & feed their friends.

My programs aren't being run as set up in my planning meeting & no one cares.

My meds. aren't checked on as ~~the~~ required. I was over medicated & got very sick & fell. They raise & reduce our meds with no explanation to us. They changed our psychol. & we had no choice in that. They did this because the new guy would do this for less money.

We have lived through cockroach infestation lasting 6 mo. I lost many of my personal items because of this infestation. We had to eat where we could because we couldn't keep food in our apt. Anita Ellis used her own money to feed us many times as program money was not available to us. During this time they added 2

extra clients that program money was not allotted for. Pam Grone, a staff person also helped feed us.

Scott, one of the staff took VCR's, clocks, groceries, and many other things. Staff use to bring their laundry to work to wash and dry. They used all our laundry supplies.

Scott would have his friends come over and eat our food. They broke our furniture while rough housing. Scott does not have a drivers license and he use to take the van without permission. He even got arrested for driving without a drivers license. One of the home managers lashed him out.

Scott use to yell @ the clients and hit and pushed them around. He scared us and other staff started treating us the same way he does. Scott never got in trouble for his actions. In fact he got a bunch of money and a good recommendation from ASI.

And Scott bragged to every one how he got away with it.

There were times when we were left alone @ the program without any staff. This happened because staff didn't show up.

for their shifts and the staff that ~~was~~ was on wouldn't wait for anybody to take over.

I got an insurance check from my dad when he died and Randy Wardlow kept it. He said he was going to use it to pay back room & board. I never saw the check again and ASI has refused to let me see what happened to it.

ASI tried to keep me from seeing my friends. They tried to have them arrested. Whenever I speak to Bud, Marlene, or Anita they come and talk to me to try and get me to turn against them. They said that they're a bad influence on us and that every time we see them that we act out or get into a bad mood. The reason why we get into a bad mood is because they hassle me and make me feel bad for having any thing to do with Bud, Marlene, and Anita. We've been told (me & Joe) that if we continue to

see Bud, Marlene, + Anita
that we're going to get into
trouble, be grounded, or lose
privileges.

Pam Trone + Scott Dillinger
keep calling me and asking
me about Anita, Bud, Marlene,
and ASI. I had my phone
number changed. Pam took
my Bank ATM card over
a year ago and was using
it to withdraw money from
my account in Woodlawn Washington.
Pam was not supposed to use
ATM cards. I think she was
using my money to live
off of but I don't know for
sure.

A lot of good stuff are
gone because ASI thought
they were friends of Anita's.
Some of those staff were let
go and demoted. The staff
are mad @ Anita because of
it. They think it's her fault.
ASI is being mean to them.

I want to move into
a better program. I want to
know exactly what happened
to my money. I want to
choose my own doctors.

I want to choose my own friends. I want to know about my medical changes and why. I want to know what is in my medical records. And I want a sponsor/advocate to help me to get the things I want and need.

Staff have pressured me into calling Bud and saying terrible things to him. The staff and some lady from the state have threatened me with eviction from Causey and the possibility of going to Oregon State hospital if I signed or sent any letter to Washington D.C.

I want someone to listen to me and help me go to a program where I will be treated right.
 Leeroy Synoground 786-1952
 3-24-93

P.S. I want to talk to Ron Wyder and Gladys Forrier. Please have them call me at my phone number.
 Leeroy Synoground 3-24-93

PSS. I called OAC and they said they didnt want to get involved. I want help to move and to get what is mine back. Mainly my money. Leeroy Snoground

(1)

Marlene J. Carson
8325 S. W. 191st
Aloha, Oregon 97007
503-591-1184

March 8, 1993

Ms. Pat Chaney, Executive Director
Alternative Services of Oregon, Inc.
18965 S. W. 84th
Tualatin, Oregon 97062

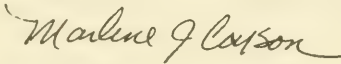
RE: Financial Records

Dear Ms. Chaney:

As guardian to my son, Douglas Eichler, I continue to express my interest in his financial status during his tenure with Alternative Services of Oregon, Inc. On several occasions ASI was requested to provide financial data and little, if any, provided. In a meeting on June 13, 1992 with Mr. Art Mack he agreed to provide any data desired. On June 29, 1992 and July 15, 1992 this request was stressed again. After repeated requests, ASI submitted a statement of Direct and Allocated Costs for Douglas Eichler for a month in 1992. It is not certain what month the printout correlated with as the month was written in pen on the statement prior to the typewritten year. The statement was prepared by Financial One, the for-profit affiliate of ASI, but there was no identification of the source of the data. Was it prepared from actual financial records or was it created to accomodate the request? In any event a subsequent request for backup data to substantiate expenditures was ignored by your company.

I am requesting that you provide me by March 19, 1993 a complete accounting of all revenues associated with my son Douglas Eichler. In addition, I would like a complete breakdown of all expenditures made of revenues associated with Douglas. Furthermore, you should indicate the source of both revenues and expenditures and the location of backup records for auditing this data.

Sincerely,



Marlene J. Carson

cc: Legal Counsel

(2)

THOMAS G. D'LUGE, P.C.
Attorney at Law
20 S. Gratiot, Ste. 114
Mount Clemens, MI 48043

Telefax number transmitted from:
313-468-2257
313-385-5662

TELEFAX COVER LETTER

DATE: 3-19-93 TIME: _____ TOTAL PAGES: 2
(Including Cover)

PLEASE DELIVER TO: MARLENE CARSON
LOCATION: FAX # 503-641-1390
FROM: THOMAS G. D'LUGE

COMMENTS:

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March 19, 1993

via fax transmission
503-641-1390

Ms. Marlene J. Carson
8325 S.W. 191st
Aloha, OR 97062

RE: Alternative Services-OR, Inc.

Dear Ms. Carson:

I am writing to you in response to your correspondence of March 8, 1993 addressed to Ms. Pat Cheney, Executive Director of Alternative Services-OR, Inc. We do acknowledge that during the spring and early summer of 1992 that you had requested certain fiscal information regarding your son's care at Alternative Services-OR, Inc. This information was provided to you in July of 1992 and since that date we have not been advised of any other request for other fiscal information prior to your correspondence of March 8, 1993. The printout of direct allocated costs was for May, 1992. The month was written onto the statement of direct allocated costs as the typed 5 did not come through on the faxed copy. This information was prepared from actual fiscal data.

We will be unable to accommodate your request that we provide you with a complete accounting of all revenue associated with your son as contract funds are not accounted for by client, but rather by a total residential program. This information is reviewed on a periodic basis by the State to assure its accuracy and our compliance with State guidelines. We trust this satisfactorily resolves your concerns.

Very truly yours,

THOMAS G. D'LUGE, P.C.

By:

Thomas G. D'luge
Thomas G. D'Luge
for the firm

TGD:ksd

cc: Pat Cheney
Arthur F. Mack
Leigh Gerhardt

Anita Ellis
14553 S. E. Kingston
Milwaukie, Oregon 97267
503-654-2661

My name is Anita Ellis. I am from the State of Oregon and I have 14 years experience in the mental health field. I am a former employee of three different care providers for developmentally disabled adults and am also a former care provider for the aged in adult foster care. I began my career in 1977 providing direct care in an intermediate care facility. My responsibilities were to follow all individual service plans for each resident. My experience there was positive. Parents and families were involved and most were satisfied with the level of care provided for their loved ones.

This provider managed one of the first group homes in the area. After approximately two years I transferred from the intermediate care facility to the group home setting where we maintained the same positive level of quality care for each individual. I left this employment to join my husband as a provider for adult foster care, but remained in contact with our developmentally disabled friends and served as community advocate.

In 1988, finding myself as a single parent with children to support, I sought employment at an intermediate care facility and was rehired. I was transferred to their group home program and I was soon promoted to Assistant Program Manager for two group homes. Many things appeared to change over the years. There did not seem to be as much family involvement and staff was not client oriented. The level of training was still very good, but incentives were not present for pay raises.

After a few months in this position, I transferred to their work activity center. The Program Manager for the center had recently resigned and the program was in transition. There was no work for clients and the program floundered. The center at that time was more or less a baby sitting service and I was dissatisfied with the situation. I applied for a Group Home Manager position with another organization and accepted employment on October 9, 1989. I was appalled at the operational climate of the organization and the challenges facing me. The group home had been operating since January of 1989 without a license or certification. There was no habilitation or training programs, nor was there transportation available for clients. The clients in this home were terribly mismatched. It has been said that this placement was due to an oversight by the development team when the program was originally

planned. One person, a wheelchair bound and non-verbal resident, paid the price for this oversight by the loss of an eye. The resident's roommate was extremely violent and destructive, had destroyed thousands of dollars worth of furniture and used a broomstick to poke the wheelchair bound resident's in the eye, causing him to lose his eye.

Many serious incidents have occurred in that particular program. These incidents included theft of a computer device, being used by the wheelchair bound resident who lost his eye, as his primary means of communication. Other incidents included forgery of physicians' signatures, medication errors, missing documentation, client abuse and negligence. I was told to file a report with the insurance company who denied the claim due to an error made by the provider in completing information forms at the time of enrollment. I approached the provider again to seek a replacement device for the resident. The provider told me to have the case manager replace the device through funds **taken from the client's trust fund**. The case manager told me to go back to the provider and tell them the responsibility for replacement resided with the provider. I did as instructed, but the provider refused to replace the device in spite of my pleas. The device **was not replaced** during the two years I was employed by this agency.

I was told by a reliable source that the new provider was brought in by the State of Oregon Mental Health Division. The new provider made grandiose promises to staff about benefits and program improvements that would take effect February 1, 1990, but later attempted to back out of promises. Staff threatened to quit and, eventually, a compromise was reached and accepted by staff.

Initially, the new provider furnished some much needed staff training. There were plans for cosmetic changes and improvements including new furniture and equipment. For the first time in the history of this program, there were individual service plans for each resident, and staff followed through with these care plans. This program was licensed and certified for the first time after one and one-half years of operation. I was promoted to Program Manager and asked to be involved in the development of new programs.

When clients were interviewed for possible placement in these new programs, I was told to be quiet and follow the lead of our development person. Most, if not all, of the residents interviewed were medically and/or behaviorally involved. Some were arsonists, pedophile,

thieves, and murderers. Many were placed in the two new facilities, which resided in family settings, with little regard to individual backgrounds. Training was provided initially with the opening of each home, but the provider was reluctant to furnish any more training because of high staff attrition.

With great difficulty, each of the new homes was eventually licensed and certified. When new staff were hired it was the practice to check three references, take photocopies of identification, and have them complete employment application paper work, including a criminal history check. The criminal history check form is sent to the Mental Health Division for handling. When the form is returned with its disposition, a determination is made whether or not the individual is employable. However, the practice was to place the individual in employment before the criminal history disposition was determined.

It was and always will be difficult to maintain good staff. The pay scale is low and there are no incentives. Benefits are very weak. Providers must compete with organizations such as fast food restaurants for employees. Potential employees often select this type of work rather than contend with some of the aggressive behaviors exhibited in some of the group homes.

When a serious incident occurs or is alleged to have occurred, such as an abuse committed against a resident by a staff person, it is the responsibility of the provider to call protective services for an investigation. Staff are reluctant to complete incident reports for serious incidents, as they fear retaliation from the provider and, in some cases, from the person allegedly committing the abuse. In January of 1991, a new Executive Director took over the Oregon programs for this agency and problems began to surface between myself and this director. When I reported alleged client abuses, the Executive Director was slow to react. I knew that these alleged abuses were serious and needed attention. Repeated attempts to stress the importance of the allegations were ignored and I went to Protective Services as is required. The director became angry with me for going over his head. As a manager, I was never provided a budget to work with until September, 1991. Upon finally receiving a budget I was informed that it was inaccurate and not to rely upon the data. This budget covered but one month.

In July of 1991, one of the group home locations became extremely infested with cockroaches and the provider and the State of Oregon Mental Health Division were informed

of the problem. In spite of repeated pleas to both parties for help, my staff and I received no response until some time in late October. At this time, I summoned someone from the Mental Health Division to come and personally view the problem. This individual, after viewing the infestation, was appalled and approved diversion funds to assist the residents in staying in a motel while their residence was being fumigated and cleaned. It was at this time that the Executive Director came to visit this program for the first time. He refused to even walk in to the apartments. After the apartments had been professionally fumigated and cleaned, the residents were forced to move back even though there were still live cockroaches. In good conscience I could not make them stay in their infested apartments and arranged for them to camp out in my office and at the other two group homes. I was working around the clock as were the other home managers. Finally, diversion monies were allotted for a group home site and the purchase of new furniture and supplies. We were told we could not take any fabrics, porous surfaced items, appliances or papers from the infested site to the new site. We had to place all of these items in storage to be fumigated and donation to others in need. At the new site it was our problem to, not only do all the moving ourselves, but that we must also purchase all the new furniture and supplies. Once again, we worked around the clock with no assistance from the agency or the Mental Health Division. The move was finally completed in December of 1991 and I proceeded work on client programs. I had just assumed responsibility of my former group home along with my Program Manager's position. An on site inspection was scheduled for December. It is a matter of record that during my time as Program Manager for the home, we received top scores during on site inspections. I maintained this high rating for all homes under me. Previously, under another Program Manager, the group home had seven different Home Managers in approximately one years time. To my great distress during my tenure I was not able to correct all problems in the program. The program was not fully staffed or adequately trained and the program failed on site inspection miserably.

When the on site team interviewed staff individually, we were informed that our conversations would be held in strict confidence. Yet, some of the things that were stated in confidence were communicated to the Executive Director, as was revealed in this person's anger toward us.

Please remember that I was still Program Manager for two other group homes during all this pandemonium. These were still problems in the newly sited program. These was no food.

The Home Manager was not available. I purchased food with my own money. I telephoned the Home Manager and left messages, but was unable to contact him. Finally, after Christmas, I was able to make contact with the Home Manager to get resident's finance logs. There were missing pages, bank statements were missing and had to be ordered from the bank. Receipts did not match expenditure records. I reported these inaccuracies to the Executive Director, and he ordered me to perform a client audit. I completed one audit (once again an around the clock ordeal) and found that there was a possibility that client funds had been misused. The Executive Director immediately suspended me without pay on January 9, 1992 and handed the finance logs and check books to the individual I had implicated. This individual continued to mishandle client funds and actually forged my signature on checks. I called the Oregon Mental Health Division and reported this activity. **They did nothing.**

I requested meetings with the provider to try to resolve the situation but they refused. Many staff were angered and wrote letters on my behalf. Staff also telephoned me at home following my suspension to tell me that my files and records were being removed from my office and fed into a paper shredder. The Home Manager I had implicated was eventually discharged. Eventually, I received a letter from the provider explaining that my suspension had been elevated to termination. I was never given the dignity or courtesy of a meeting to discuss the reasons for my termination.

I have steadfastly applied for every job opening in the mental health field. This resulted in one interview. I have observed personnel managers, whom I had never met, who upon reading my name at the top of the application form, shake their heads and return the application to the receptionist. I have good reason to believe that I have been blackballed in both the private and public sector on this industry, a field for which I have extensive training and experience.

Many of the residents I served have been denied access to me by the provider and the Oregon State Mental Health Division. Many staff who have worked with me and who have offered me support have been harassed, demoted or forced to leave employment with this agency. These actions took place following the onset of an investigation and airing of a five-part series on this agency by the local affiliate of a national television network. The agencies attorney and new Executive Director approached some of these staff personnel and asked

them to sign an affidavit falsely accusing me of improprieties. And in one such case, the individual, who was under investigation for client abuse for the forth time, received five weeks severance pay and a letter of recommendation in exchange for a deposition falsely accusing me of these improprieties.

I am not appearing before you to bash my former employer and I remain hopeful that this situation will change and that I can return to the field for which I am highly trained and qualified.

March 23, 1993

Rep. Ron Wyden, Chairman
Subcommittee on Regulation,
Business Opportunities, & Technology
B-363 Rayburn House Office Building
Washington, D. C. 20515-6318

Dear Rep. Wyden,

We would like to submit the following as testimony regarding our experience with the Michigan mental health care system as related to the sexual abuse of our retarded daughter by an adult foster care facility operator owner.

For the record we are Gerald C. Oakes Professional Engineer - Village Manager and Joan B. Oakes Homemaker - Artist. Our residence is 439 McIntosh, Village of Almont, State of Michigan, County of Lapeer. We have four children the youngest is Maureen (31 yrs.) who is mentally retarded and subject to seizures. Her overall mental age is 12.7 years. Maureen lived at home until she was sixteen when she was placed in a private Catholic Residential Boarding Home for handicapped girls, Our Lady of Providence, Operated by the Sisters of Providence. She remained in this school for six years when she was placed by the St. Clair County Department of Social Services in a small A.F.C. home in that county. She stayed in this private home for nine months, when she had behavior problems, and was transferred to a second A.F.C. home in Marysville again in St. Clair County. Again she stayed about nine Months when she had extreme violent acting out tantrums and we were asked to remove her. In the mean time we had moved out of Detroit to Lapeer County. In early 1987 we contacted the Lapeer County Mental Health Agency (CMH). They helped us place Maureen in His Majesty's Christian center (HMCC) in Otter Lake, Lapeer County. Since leaving HMCC after the abuse she has been in two A.F.C. homes in Lapeer County. She continues to have behavior problems which result in violent lashing out against the people around her, which is the reason she is not at home. She is difficult to handle in a normal setting. She needs constant supervision and rebels when she becomes frustrated, sometimes very violently and physically aggressive. We have sought specialist medical treatment for her behavior problems for many years. She is presently on Depacote for seizures, Benadrill for sleeping, which is a problem. Some of the medications she has been on in the past are Phenobarbital, Dilantin, Mellaril, Halcion, and Ovcon.

The Otter Lake facility was only open about a year when Maureen entered. The staff seemed very caring, the name His Majesty's Christian Center was very reassuring to us. We were very trusting relying on the owners Dave and Marion DeLauter who seemed very trustworthy and understanding of our problems with Maureen. We had no detailed knowledge of the types of licenses held at HMCC, we trusted the CMH case worker to know that the requirements were being met. At the time Maureen was placed at HMCC we were suffering emotional burn out due to many years of dealing with the violent acting out by our daughter. We were not aware of our rights or our daughters rights under the mental health care system. We were not told our rights.

The HMCC facility was an old American Legion boys home. It had two old dormitory type buildings a modern occupied senior citizens building, a gym, two small homes and a maintenance building. The building Maureen was assigned to housed eleven residents, four males on the second floor, and seven females on the first floor. During the four years Maureen was a resident at HMCC the DeLauters expanded utilizing the other buildings in the compound. At one time CMH leased the large building known as the gym for their day care program and some of the CMH staff offices until CMH's new building was completed. We only became aware of the drug abuse residents about six months before Maureen left. We believe it was at the last annual Christmas party for residents and families that we became aware of the large number of what we thought were people in the drug abuse program mostly males. We did at that time ask Maureen if she had any problem with anyone at the facility, she said no and she said she saw very little of the men in the drug program. Again we trusted the DeLauters and CMH to protect our daughter. It was after we learned of Mr. DeLauter's sex abuse of the six residents that we found out about the felons being housed at HMCC.

We were never aware of anything that we could classify as impropriety until the sex abuse came out on February 24 1991. We were not always impressed with some of the workers as we were not sure of their ability to handle the residents but we always trusted the DeLauters to protect our daughter. They lived on site which made us comfortable. Also there was a strong religious influence at HMCC, we allowed Maureen to participate as a member of their Church. She was Baptized at the center and in some way this gave us a general feeling of security for her. We did limit our contact with Maureen to break her dependency on us. She started to call Dave DeLauter "dad" we did not object. We were very pleased with the growth we saw in Maureen. We were told she had progressed in improving her ability to deal with her temper.

She did not complain, she was very happy. She did say she was working at the work shop too much and DeLauter cut her hours. she attended adult education on the grounds three days a week which she loved. The summer of 1990 we became aware of her weight gain, hand tremors and sores on her hands and legs, which she picked at. HMCC took care of her medical needs, when asked if they were treating the sores she said sometimes. Again we were not overly concerned we thought it could be a side effect of her new anti convulsant medicine. We did talk to the staff and DeLauter about these medical problems. In a matter of days after Maureen was moved out of HMCC her sores began to heal and the tremors subsided. Maureen did tell her mother about having bladder infections but because she did not understand about proper hygiene it was assumed that was the cause. We were told after the abuse came out that 19 female residents were treated for recurring bladder or vagina infections. We were not told by HMCC about this treatment which we now know is a violation. However since we were relieved of the behavior problems and Maureen seemed happy our concerns were not raised.

It was through the work of a Detroit News Investigative reporter that we became aware of most of these things. Also getting to know the families of the other females involved in the abuse we heard of their daughters difficulties and what they told them about what was happening. We also learned through the newspapers about two CMH workers who had been told by two female residents of HMCC that they were being sexually abused by Mr. DeLauter. Because they were M.I.'s known to hallucinate they were not believed. The workers claim they told their supervisor and nothing was done.

To describe how we were notified about the abuse I will start with the day before, Saturday Feb. 23, 1991 When we made arrangements to pick up Maureen for the afternoon to take her shopping and out to eat. We always feel some apprehension when we are with her because we never know when she might become moody or demanding, although she had improved we still felt tense. It turned out to be the most pleasant afternoon we had with her in years

On Sunday afternoon at about 1:30 pm Marion DeLauter called. She asked how our Sat. afternoon had gone, she was told it went very well. She said you had better sit down because of what I have to tell you. I said I was sitting and she began with "your daughter and four or five other female residents are accusing Dave of sexually abusing them." I replied oh my God, and made reference to how upset she must be. I can not recall what else I said but asked if I could call her back after talking with my husband. We were both stunned and could not think clear finally I said we had to go out there and talk to Maureen. I called Marion and said we were on the way, she said to come to their home first before seeing Maureen.

It is a 45 minute drive to HMCC from our home we spoke very little during the trip. We just could not believe Maureen could make something like this up because she has not been sexually active and really doesn't understand about sex. We both kept hoping there had been some mistake or misunderstanding. That it could not be true we didn't want it to be true. Yet we both somehow knew something had happened. We arrived at the DeLauters house at about 2:45 PM both Marian and Dave talked to us, mostly Marian. They explained this accusation was made on Sat. evening, staff did not follow their procedures, which was to call them or Sue Sanford in case of an emergency. Staff did call another staff person who called the Lapeer County Sheriff, which is the correct procedure under the law. The sheriff called in a female deputy who questioned the females most of the night. We found out there where four females involved. We asked Marion if we could have the phone numbers of the other parents, since they had already picked up their daughters. Marian and Dave said the girls were together in one of their bedrooms on Sat. Night making up this story. Marian also said all three girls used the same story word for word. She said three because one of females was home for the weekend and could not have been in on the plot. Dave mentioned they said only fondling and oral sex but no intercourse was involved. Dave gave us the key to his private office in another building he said we could use it to talk to Maureen in private. We found out later he had the office intercom open to his house so they could monitor us. Maureen was sleeping and had to be awakened, she had been up all night. We took her to Dave's office in the NW corner of the building we found it locked with two locks. Once we were in the office we asked Maureen what had happened. She was very uncomfortable and reluctant to talk. She said one of the girls had talked to staff on Fri. night and that the Police talked to her on Sat. night. We asked her to tell us what she told the Police.

Maureen said that Dave had her come to this office and did relaxing exercises with her. She said he touched her BOOBS (her word) and he touched her there, she pointed to her crotch. She said sometimes the other girls were in the room also. I asked if he locked the door she said yes. I asked if she felt uncomfortable and did she want to come home. She said yes. We packed a few things and took Maureen to the car. We went back to DeLauter's house to return the keys. At some point Marian said they could not go into the Bennett building, the girl's dorm, at which Dave said no one could stop him from seeing his girls. Marian gave us the phone numbers of the other parents and we left. I did recommend to Dave that he get a good Lawyer.

We were very sure something had happened we were not sure of the details. However over time it became very clear that David DeLauter had sexually abused four or more mentally handicapped females under his care. At first we were in shock we went about our normal business of living as best we could. Maureen felt a great deal of shame she felt she was bad and had created a problem for us. We in turn felt a great deal of guilt since we had put Maureen in this position we should have picked up on this person we should have seen the signs. When we placed her in HMCC we told her to be good and to do what Dave and Marion tell her to do. We had to assure Maureen that she was not to blame that DeLauter had taken advantage of her and the others. That was a crime for which he would be punished. This crime drastically affected our lives for the next twelve months until Delauter was found guilty and sentenced to 25 years minimum. Initially we floundered within the criminal justice system and the mental health system. Joan spent many long hours on the telephone trying to get help. Our marriage relationship was affected we pulled away from our friends and family.

We notified HMCC that Maureen would be remaining with us for now and we asked CMH to look for another placement. We had planned a trip to Disney World with our grandchildren for early March. We took Maureen and it was a very stressful experience. Maureen was very resentful and seemed in a shocked state.

We were asked to bring Maureen to the Lapeer State Police Post on Thurs. Feb. 28, 1991 for questioning. We asked to be in the room when she was questioned and were refused. Adult Protective Services was with the officer so we felt better. Our fear was that because Maureen was retarded and did not understand what happened to her she would not respond to the questions as a normal sex victim would, we continually tried to ask that the police and later the Attorney General obtain experts to assist in the questioning we were refused. We obtained the information we had from the newspapers, the other parents, and bits and pieces from the people involved. For instance well into the investigation the State Police officer mentioned intercourse was involved. When I said we did not know that he said didn't your daughter tell you. We did learn most of what happened to Maureen by eavesdropping on the questioning of her by the Department of Licensing which in total made six times she had to repeat her story. We found out that not only intercourse but anal and oral sex was involved. Also two or more of the females were in the room and they fondled each other, at DeLauter's direction.

Some of the case workers reported their suspicions to the HMCC Manager Sue Sanford, again nothing was done. DeLauter even forced one of the females to sign a letter saying it was a lie. How did he control these people. He controlled their life he decided if they were rewarded or punished, he would threaten them with being sent to the State Mental hospital. He used physical force on the males and threatened the females. The staff was reluctant to pursue their suspicions because they would lose their job.

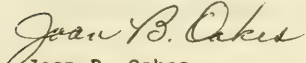
The Department of Licensing investigation seemed pro owner and gave little consideration to the impaired females. We could not see why the dept of licensing could not share the State Police investigation why did these victims have tell and retell their story six times. We called many agencies to try to get some protection for our daughter and to make sure the guilty party was punished. We did finally retain an attorney to represent Maureen and that worked very well. Our attorney was able to intervene into the Licensing hearing and delay the appearance of the victims at the hearing until after the trial. However when he was found guilty they had to pull HMCC's AFC license. Our attorney was able to communicate with the A.G.'s staff to help us or reassure us that justice would be done. We at all times felt that the State would not incriminate itself. That they would cover up the failures of the system to protect the victims. We have to thank a number of individual people who did their job and let the chips fall where they may.

Our daughter, Maureen is in her second A.F.C. home since the incident. She continues to have behavior problems and has had counseling from a sex abuse specialist. We have attached a copy of the therapists report on the effects of this abuse on Maureen. The second female lives in Genesee County with her parents and works in a A.F.C. home owned by a family friend. The third victim moved twice since the move from HMCC the first home was closed by Licensing. She is not in any workshop or day program. She has gained a lot of weight and is taking a great deal, of medication. Her mother is concerned about her placement but has nowhere to turn. The fourth female lives in Western Michigan near her family she is in a A.F.C. home attends a sheltered workshop and seems well adjusted only she has a closed head injury which limits her long term memory she probably does not remember what happened. The fifth victim had many problems in Lapeer County with placement and went into the Caro State hospital for a time. She has relocated to Sanilac County just North of Lapeer in an A.F.C. home.

We hope this addresses most of your concerns. We know it is kind of rambling but we could have filled twenty pages with what we experienced. The bottom line is we seem to be sacrificing our most vulnerable people on the altar of cost savings. The question is can the private enterprise system and its profit driven needs deliver compassionate care to our mentally and physically handicapped citizens. The record is not good, please help us. Thank you for your time.



Gerald C. Oakes



Joan B. Oakes

SEXUALITY EDUCATION AND ENRICHMENT FOR THE DEVELOPMENTALLY DISABLED
 Sexuality Services Case Consultation

Name: Maureen Oaks
 Date: 2-26-93
 Submitted by: Susan Groves

SOCIAL/SEXUAL CONCERNS, QUESTIONS AND/OR OBSERVATIONS PRECIPITATING CASE CONSULTATION: (Continued)

Information for this report was obtained through consultation with the following individuals: Maureen Oaks (client), Joan and Gerald Oaks (biological parents), Jim Wilcock (psychologist/Lapeer County CMH), Kay Blair (case-manager/Lapeer County CMH), Sharrie Rhein (Michigan Dept. of Social Services/Adult Protective Services), Elaine Harrison (former foster parent), Barbara Kirkland (foster parent), Suzan Sanford (Assistant Attorney General)

Maureen Oaks is a 31 year old female diagnosed as mildly mentally retarded with a full scale IQ of fifty five. She is currently residing at the Kirkland Foster Home and attends the Adult Day Activity Program at Lapeer County Community Mental Health.

This case consultation review was prompted by concerns expressed by Joan and Gerald Oaks regarding the effects of past incidents of sexual abuse of Maureen at His Majesty's Christian Care Center where Ms. Oaks was residentially placed from ~~summer~~ ^{February} 1987 until February 1991. Ms. Oaks disclosed her sexual victimization in February 1991. These incidents were perpetrated by the administrator of this facility and were reported to have been ongoing over a period of several years. These incidents of abuse were reported to have occurred primarily in the office of the administrator (Maureen remembers one sexual interaction also occurring at the home of the administrator.) during "relaxation sessions" where the administrator performed various sexual acts on these women. At other times he instructed them to perform sexual acts on each other. Ms. Oaks recalls having conflicting feelings about being summoned to this man's office because of the uncertainty about what may occur. The administrator was clearly perceived as the authority at this facility and at times was reported to be a rather harsh disciplinarian. Ms. Oaks also relates numerous non-sexual interactions with this individual and definitively states that on these occasions she very much liked this man.

In October 1991, in Lapeer County Circuit Court, Ms. Oaks participated as a witness against this individual. He was found guilty of Criminal Sexual Conduct in the First Degree against Ms. Oaks and four other female residents of this facility.

(2)

SEXUALITY EDUCATION AND ENRICHMENT FOR THE DEVELOPMENTALLY DISABLED
Sexuality Services Case Consultation

SOCIAL/SEXUAL CONCERNS, QUESTIONS AND/OR OBSERVATIONS PRECIPITATING CASE CONSULTATION: (Continued)

CLIENT NAME: Maureen Oaks

DATE: 2-26-93

CLINICAL ASSESSMENT:

Ms. Oaks remains understandably confused about relationship boundaries and has developed major obstacles around trust issues that primarily effect her interactions with males. Maureen states she does not want any more boyfriends because "you can never tell what they're going to do". This mistrust (and at times fear) extends from her closest male relationships, to males she interacts with in day program (both peers and staff) as well as men she encounters only momentarily. In an attempt to reduce her fear, Maureen is now determined to keep all males at a physical and emotional distance.

Maureen states that initially she was ambivalent and confused over what was occurring at His Majesty's Christian Care Center. Though she recalls some early positive feelings about participating in "relaxation sessions", Maureen states she soon became very desirous of finding a way to stop these sexual interactions. She remembers times of wanting to tell her mother but felt she would "get caught" and then suffer ramifications for doing so from those in charge at her residential placement. Ms. Oaks' perception of being held as a physical/emotional hostage forced her into an acceptance as she endured constant sexual abuse over an extended period of time. Though these sexual interactions were not formerly or presently behaviors in any way common to Maureen, her positive attitude toward her perpetrator during this time resembled dynamics seen in those suffering from the Stockholm Syndrome. Ms. Oaks currently correctly perceives the responsibility and blame for her sexual victimization on the individual that perpetrated against her. She is now cognizant of this individual having power and authority over her. While Maureen appropriately verbalizes blame on this man for the sexual interactions that occurred, she also expresses disproportionate anger at his wife (who also worked at this facility) for failing to stop her husband (and therefore protect her?). In the future Maureen could benefit from the opportunity to share her feelings with others whose similar experiences include the perception of being unprotected by persons believed to be in a position to be able to prevent the abuse. It might also be useful to assist Maureen to develop a relationship board (with photographs and drawings) as a concrete tool to encourage discussion of various persons in her environment to determine and understand the inherent opportunities and boundaries of these relationships. This tool could also be used for relationship checks to address Maureen's continued fears and vulnerability of exploitation.

(3)

SEXUALITY EDUCATION AND ENRICHMENT FOR THE DEVELOPMENTALLY DISABLED
Sexuality Services Case Consultation

CLIENT NAME: Maureen Oaks

DATE: 2-26-93

CLINICAL ASSESSMENT Con't:

Ms. Oaks initial disclosure was recieved sensitively by many mental health staff and her family. She was also provided with a supportive atmosphere by persons involved with the criminal justice proceedings in an efforts to avoid doing further damage to her. As a result, Maureen was spared further traumatization that commonly follows these proceedings. She is now able to frame these past events in a manner that have greatly contributed toward her healing.

Maureen will not readily communicate her negative feelings to her family or staff. In stressful times, she most often states that "everything is fine". Maureen continues to resist expression of her negative feelings by working hard at insulating her fears and anxieties until she blows up after obsessing about some extraneous stressor or she self-abuses (a coping behavior for her anxiety that she has historically demonstrated). Maureen will however also respond to a designated person with whom she can build a relationship of trust through regular opportunities to discuss her past and current struggles. Ms. Oaks demonstrates a need for ongoing general therapy that is less dependent for success on frequency than on regularity and access (when anxieties again become acute). A word of caution should be noted however. Maureen can easily become overly dependent with her counselor in a manner that significantly mirrors the previous dependency she had with the provider of His Majesty's Christian Care Center. Atmospheres of compliance and over-dependence should be avoided, as Maureen needs to again realize her power/ability to manage her own environment and safety while of course having awareness of the external support availables from others for this effort.

During the limited opportunity this writer had with Maureen, she was effectively able to verbalize many feeling about her past victimization. She demonstrates some progress in sorting out her conflicted feelings about these events. Maureen was very motivated to work on expanding and improving her expression of feelings. She often wrote her thoughts and feelings between our sessions in a journal and would come to appointments with these writings. It is this writers belief that from time to time, Maureen may return to periods of extreme anxiety as she is able to attempt to remove her past barriers to relationships. With periodic limited theraputic interventions in a consistant supportive environment, Maureen will feel safe to make choices and enjoy experiences available to her that are no longer driven by her past negative experiences.

Maureen's Strengths:

- can verbalize her feelings
- is motivated to do so with a designated individual
- has a basic and healthy perspective on her past sexual victimization

Maureen's weaknesses:

- has a tendency to initially deny her negative feelings
- has enmotional scarring from past incidents of abuse
- has a distrust of all males
- has confuion regarding relationship boundaries that both unnecessarily limits her and continues to render her vulnerable for abuse

(4)

SEXUALITY EDUCATION AND ENRICHMENT FOR THE DEVELOPMENTALLY DISABLED
Sexuality Services Case Consultation

CLIENT NAME: Maureen Oaks
DATE: 2-26-93

RECOMMENDATIONS:

- 1) provide ongoing general counseling
- 2) consider future participation in a women's survivor group
- 3) address confusion of past and present relationships through development of a relationship board as a communication and teaching tool to demonstrate boundaries and opportunities with others in her environment
- 4) anticipate and provide periodic short term sexual abuse crisis intervention as Maureen is ready and as future events warrant
- 5) avoid environments that encourage over-compliance/support responsible independent choices



Susan Groves
S.E.E.D.D.
Consultant Counselor/Date



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COMMONWEALTH OF MASSACHUSETTS

REMARKS OF ALPHONSE V. MEDONIS, REGIONAL ADMINISTRATOR
AND DIRECTOR OF SPECIAL AUDITS

Also in attendance:

Paul McLaughlin, Audit Specialist

Richard Powers, Senior Forensic Auditor

Paul Stewart, Assistant Forensic Audit Manager

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Thank you Mr. Chairman and members of the committee. It is a pleasure and a privilege to appear before you this morning on behalf of State Auditor A. Joseph DeNucci, Auditor of the Commonwealth of Massachusetts. Before I begin, I would like to take this opportunity to introduce my colleagues; Paul McLaughlin, Richard Powers and Paul Stewart.

I have been asked to comment on our experience in the Commonwealth of Massachusetts with respect to illegal acts, waste and abuse in the billings by vendors that provide services to the mentally retarded and developmentally disabled. The industry is generally honest, however, our experience has shown that providers are routinely reimbursed for items that are unreasonable, or unallowable under the existing regulations.

Additionally your committee has asked for our views on improving the system. After reading our prepared remarks, we are ready to answer any questions from the committee members.

The Commonwealth of Massachusetts has been utilizing private contractors as an important part of its human service network for over twenty years. A substantial percentage of the services provided in this area are to mentally retarded and developmentally disabled individuals. During this period the industry has grown from a small number of community oriented service providers to a significant industry including providers who operate in multiple states or serve clients from many other states and foreign countries. Private providers serving these populations in Massachusetts are currently regulated by no fewer than five state agencies.

The explosive growth in this industry, spurred by deinstitutionalization, outstripped the Commonwealth's ability to effectively regulate the programmatic content and financial conduct of provider groups. The different priorities of purchasing and regulatory agencies resulted in duplicative and, in some cases, contradictory regulations. By the late 1980's the system had

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reached the point of virtual gridlock. Regulatory agencies were no longer able to coordinate the licensing, rate approval, program development, and oversight procedures in a timely or useful manner. In an attempt to break this logjam a new rate approval process was established. As in previous attempts, these changes failed to develop a stable, responsive, and cost effective network of providers.

During the past several years, State Auditor A. Joseph DeNucci's office has completed a series of audits which have demonstrated the weaknesses inherent in the current system. These systemic blind spots have allowed certain providers to engage in illegal activities and to divert funds to inappropriate uses. In three cases alone we have identified, and the Commonwealth of Massachusetts is attempting to recover, over seven million dollars. We believe that stronger reporting requirements, review techniques, development of specialized audit plans, and a combination of selected and random audits, would lead to the identification, detection and recovery of \$50,000,000 of state and federal funds.

The absolute reliance of providers on the rate, combined with the absolute need for the services provided by them, has created a situation where each party holds the other hostage. This is not only unhealthy it is expensive. Providers protect their rate structure by exhausting income on reimbursable costs, therefore, when an unexpected expense or fluctuation in enrollment occurs they are forced to seek a rate adjustment. Conversely, when a program encounters financial difficulty the purchasers need to protect their clients. This is normally accomplished by increasing the financial commitment to the provider.

Since rates are generally approved on a unit or enrollment calculation, providers must operate at or near capacity to break even. The practice of expending resources to maintain rate integrity leaves few providers with

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resources available to expand operations to meet a new demand for services.

The existing methodologies do not lend themselves to timely rate processing and program approval. This prevents the purchaser from using new programs as placement options. These system weaknesses make it easier to increase funding to a struggling program rather than find a long term effective solution.

We also believe a more effective regulatory process and a re-definition of the providers' role could result in an additional \$60,000,000 in savings.

We feel confident in these projections for two reasons. First, the reimbursement system in the Commonwealth has never truly promoted effectiveness, but has given tacit approval to wasteful procedures through regulations that use program expenditures to justify cost as opposed to measuring program effectiveness in determining value. Oftentimes improper allocations of direct costs, schemes that lead to personal enrichment, and excessive executive salaries and benefits are included in the final rate of reimbursement. A two and one-half percent increase in effectiveness over the Commonwealth's estimated \$2 billion in expenditures results in \$50,000,000 in savings.

Secondly, the elimination of accountability, controls and external audit presence has created a safe haven for those who choose to abuse the system. The failure to disclose related party activity in real estate transactions and many other activities simply are not picked up in the course of a so-called desk audit. The results of our field audits indicate that certain basic strategies are employed on a recurring basis to drain funds from the system. These strategies result in excessive costs being passed to the Commonwealth through the following types of undisclosed related party transactions:

- First, Real estate transactions where the provider is both the lessee and owner.
- Second, Shell companies set up to procure goods and services, add an artificial layer of cost, and deliver them to the provider.
- and Third, For-profit management companies to manage the non-profit providers

In our opinion fraud, waste and abuse is not unique to Massachusetts nor to the provider community. The (healthcare) system nationwide is easy to defraud because the payor is not always a buyer or seller of the services. Therefore payors don't always know if they are getting value for their dollar.

Within the Commonwealth the human services industry is one of the most heavily regulated industries. We believe that accounting principals, and auditing standards are adequate enough to ensure proper accounting and reporting. We view the major problem as the failure to comply with existing requirements. It is in the monitoring and enforcement of these regulations that we see the greatest potential for improvement and the reduction of illegal acts, waste and abuse. Streamlined but meaningful cost reporting, combined with enforcement tools and external audits will promote compliance and a resultant cost savings.

The Commonwealth has enacted a new debarment statute, sponsored by State Auditor A. Joseph DeNucci, which allows for the suspension or revocation of contracting privileges. This process places at the Commonwealth's disposal a tool with which to promote compliance. We have, for your convenience enclosed a copy of the debarment legislation in your briefing package. Auditor A. Joseph DeNucci has also proposed legislation which clarifies the definition of and the disclosure responsibilities of related parties. This legislation when enacted will close another gap in the existing system.

What remains, is the development of industry models, simplification of the existing cost reporting system, the development of specialized audit plans and procedures and a consistent external audit presence. The most effective tool in the protection of federal and state resources is the audit. This process allows government to determine that funds expended were in fact used for the purposes intended. Unfortunately, the general procedure is for these agencies to conduct only desk audits. In Massachusetts, only the Auditor of the Commonwealth conducts external, independent and objective audits.

Desk audits are minimally useful, lack independence, and promote a cumbersome paper intensive cost reporting and rate approval process. Reporting requirements, rather than the appropriate utilization of funds, becomes the focus of the system. The cost reporting and rate review process should be separate from the audit process. The splitting of these functions allows each group to concentrate on those areas most important to them and with which they have the greatest level of competency.

The system should be streamlined so that cost information can be submitted in a timely and meaningful format. Trained and experienced auditors should review the financial operations of the providers and select vendors for audit based on the information contained in the cost submission. An additional group of providers should be selected at random for an audit of their operations. This accomplishes two equally important goals: first it maximizes the ability to identify and intervene in potentially abusive or illegal activity and secondly it allows for the development of industry statistics and norms for future measurement and analysis.

It is our belief that a combination of selected and random audits will do more to increase compliance than any change in regulations. Improved oversight and the increased protection that it offers is dependent upon a more timely and meaningful reporting system.

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We as government auditors are uniquely qualified to review, analyze, and synthesize financial information for this purpose. We understand the programs and their flaws and are able to design protocols, audit plans, and develop industry models that would enhance the ability of the Commonwealth, and other states, to effectively monitor the financial activity in organizations providing services to mentally retarded and developmentally disabled populations.

In closing, we advocate streamlining the cost reporting process, intensifying the audit process, and incorporating penalties, such as debarment, to ensure compliance with existing regulatory standards, combined with meaningful regulations that identify specific costs and activity that are unallowable, unreasonable and therefore not reimbursable.

We thank you Mr. Chairman. We would be happy to answer any questions.

MASSACHUSETTS GENERAL LAWS
CHAPTER 29

§ 29F. Debarment or suspension of contractors; list

(a) As used in this section the following words shall, unless the context requires otherwise, have the following meanings:—

"Affiliates", entities which are affiliates of each other when either directly or indirectly one concern or individual controls or has the power to control another, or when a third party controls or has the power to control both.

"Commissioner", the commissioner of the division of capital planning and operations or his designee within such division.

"Contractor", any person that has furnished or seeks to furnish supplies or services under a contract with a public agency or with a person under a contract with a public agency.

"Debarment", an exclusion from public contracting or subcontracting for a reasonable, specified period of time commensurate with the seriousness of the offense.

"Public agency", a department, agency, board, commission, authority, activity or instrumentality of the commonwealth, or of any political subdivision of the commonwealth, or of two or more subdivisions thereof.

"Person", any natural person, business, partnership, corporation, union, committee, club or other organization, entity or group of individuals.

"Public contract", a contract for the furnishing of supplies or services to any public agency.

"Secretary", the head of an executive office established under chapter six A or his designee within such executive office, or the secretary of administration appointed pursuant to section four of chapter seven or his designee within the executive office.

"Suspension", the temporary disqualification of a contractor who is suspected upon adequate evidence of engaging or having engaged in conduct which constitutes grounds for debarment.

(b) The secretary of administration shall establish and maintain a consolidated list of contractors to whom public contracts shall not be awarded and from whom offers, bids, or proposals shall not be solicited.

The list shall show at a minimum the following information: (1) the names of those persons debarred or suspended in alphabetical order with appropriate cross reference where more than one name is involved in a single debarment or suspension; (2) the basis of authority for each debarment or suspension, including the secretary or other official who imposed the debarment or suspension; (3) the extent of restrictions imposed; (4) the termination date of each debarment or suspension; and (5) in the case of a suspension, the hearing date, if and when set, for debarment proceedings.

The secretary of administration shall cause the list to be kept current by the issuance of notices of additions and deletions. The list shall be published on a periodic basis, together with notices of additions and deletions therefrom, in the goods and services bulletin and the central register published by the state secretary and in such other publications as the secretary of administration shall designate. The secretary of administration shall also forward said list to the inspector general, the attorney general, and the state auditor. A secretary or the commissioner, as the case may be, upon imposing a debarment or suspension or removing a suspension shall forthwith notify the secretary of administration of all information required for inclusion on such list.

(c) Debarment may be imposed for the following causes:

(1) conviction or final adjudication by a court or administrative agency of competent jurisdiction of any of the following offenses: (i) a criminal offense incident to obtaining or attempting to obtain a public or private contract or subcontract, or in the performance of such contract or subcontract; (ii) a criminal offense involving embezzlement, theft, forgery, bribery, falsification or destruction of records, receiving stolen property or any other offense indicating a lack of business integrity or business honesty which seriously and directly affects the contractor's present responsibility as a public contractor; (iii) a violation of state or federal antitrust laws arising out of the submission of bids or proposals; (iv) a violation of state or federal laws regulating campaign contributions; (v) a violation of chapter two hundred and sixty-eight A; (vi) a violation of any state or federal law regulating hours of labor, prevailing wages, minimum wages, overtime pay, equal pay, child labor, or worker's compensation; (vii) a violation of any state or federal law prohibiting discrimination in employment; or (viii) repeated or aggravated violation of any state or federal law regulating labor relations or occupational health or safety; or

(2) substantial evidence, as determined by a secretary or the commissioner, of any of the following acts: (i) willfully supplying materially false information incident to obtaining or attempting to obtain or performing any public contract or subcontract; (ii) willful failure to comply with record-keeping and accounting requirements prescribed by law or regulation; (iii) a record of failure to perform or of unsatisfactory performance in accordance with the terms of one or more public contracts, provided that such failure to perform or unsatisfactory performance has occurred within a reasonable period of time preceding the determination to debar and provided further that such failure to perform or unsatisfactory performance was not caused by factors beyond the contractor's control; (iv) a record of health and safety violations of a sufficient frequency and severity so as to evidence a pattern of noncompliance with existing state and federal laws, or any rules and regulations applicable thereto; (v) any other cause affecting the responsibility of a contractor which the secretary or the commissioner determines to be of such serious and compelling nature as to warrant debarment. Notwithstanding any other provision of this section, any contractor debarred or suspended by any agency of the United States shall by reason of such debarment or suspension be simultaneously debarred or suspended under this section, with respect to non-federally aided contracts; the secretary or the commissioner may determine in writing that special circumstances exist which justify contracting with the affected contractor. The secretary or the commissioner shall give written notice to the secretary of administration of any such determination.

(d) No contractor may be suspended unless a secretary or the commissioner has first informed the contractor by written notice of the proposed suspension mailed by registered or certified mail to the contractor's last known address, except when the secretary or the commissioner determines that immediate suspension is necessary to prevent serious harm to the commonwealth, in which case the suspension shall take effect immediately upon signing by the secretary or the commissioner of an order of suspension, and notice shall be mailed to the contractor at the earliest opportunity. The notice shall inform the contractor of the reasons for the proposed suspension and shall state that the contractor may within fourteen days respond in writing and may in such response request a hearing. The secretary or the commissioner may extend the period for response at the request of the contractor. The secretary or the commissioner shall determine whether to impose the suspension or, in the case of an emergency suspension imposed prior to notice to the contractor, whether to continue the suspension after reviewing the contractor's response, if any, and making such investigation as the secretary or the commissioner determines is necessary and appropriate. An indictment, or any information or other filing by a public agency charging a criminal offense, for any of the offenses listed in paragraph (1) of subsection (c) shall constitute adequate evidence to support a suspension.

If the contractor requests a hearing, and the suspension is not based on an indictment, the secretary or the commissioner shall conduct a hearing according to the rules for the conduct of adjudicatory hearings established by the secretary of administration pursuant to chapter thirty A. Such hearing shall be initiated within thirty days of the imposition of the suspension, unless the contractor requests that the hearing be delayed. Officers and employees of the office of the inspector general and records of said office shall not be subject to subpoena for such hearing, if in the opinion of the inspector general production of records or testimony would prejudice any pending investigation by said office.

A suspension shall not exceed twelve months unless a pending administrative or judicial proceeding in which the contractor is a party may result in a conviction or final adjudication of an offense listed in paragraph (1) of subsection (c).

(e) No contractor may be debarred under this section unless a secretary or the commissioner proposing the debarment has first informed the contractor by written notice of the proposed debarment mailed by registered or certified mail to the contractor's last known address. The notice shall inform the contractor of the reasons for the debarment and shall state that the contractor will be accorded an opportunity for a hearing if the contractor so requests within fourteen days of receipt of the notice. A hearing requested under this paragraph shall be conducted by the secretary or the commissioner within sixty days of receipt of the request, unless the secretary or the commissioner grants additional time therefor at the request of the contractor. The hearing shall be conducted according to the rules for the conduct of adjudicatory hearings established by the commissioner of

administration pursuant to chapter thirty A. A debarment shall not be imposed until (i) fourteen days after receipt by the contractor of notice of the proposed debarment if no hearing is requested, or (ii) the issuance of a written decision by the secretary or the commissioner which makes specific findings that there is sufficient evidence to support the debarment and that debarment for the period specified in the decision is required to protect the integrity of the public contracting process. A contractor shall be notified forthwith of the decision by registered or certified mail, and of the contractor's right to judicial review in the event that the decision is adverse to the contractor. If a suspension precedes a debarment, the suspension period shall be considered in determining the debarment period.

(f) A debarment or suspension may include all known affiliates of a contractor. The decision to include a known affiliate within the scope of a debarment or suspension shall be made on a case-by-case basis, after giving due regard to all relevant facts and circumstances. The offense or act of an individual justifying suspension, or the evidence justifying a suspension, may be imputed to the entity with which the individual is connected when such offense or act occurred in connection with the individual's performance of duties for or on behalf of the entity or with the knowledge, approval, or acquiescence of the entity or one or more of its principals. The entity's acceptance of the benefits derived from the conduct shall be evidence of such knowledge, approval, or acquiescence. The offense or act of an entity justifying debarment, or the evidence justifying a suspension, may be imputed to any officer, director, shareholder, partner, employee or other individual associated with the entity who participated in, knew of, or had reason to know of the entity's act. An entity or individual may not be suspended or debarred except in accordance with the procedures set forth in this section, provided that a public agency may reject a bid or proposal from any contractor when the public agency reasonably determines that such contractor is not responsible or eligible.

(g) In determining whether to debar a contractor; or the period of a debarment, all mitigating facts and circumstances shall be taken into consideration. Except as precluded by statute, a debarment may be removed or the period thereof may be reduced by the secretary or the commissioner who imposed the debarment or suspension upon the submission of an application supported by documentary evidence setting forth appropriate grounds for the granting of relief, such as newly discovered material evidence, reversal of a judgment or conviction, bona fide change of ownership or management, or the elimination of the cause for which the debarment was imposed.

(h) During the period for which a person has been debarred or suspended, that person shall not submit or cause to be submitted offers, bids, or proposals to any public agency, nor shall any public agency solicit or consider offers, bids, or proposals from, nor execute, renew, or extend any contract with, a debarred or suspended contractor, and a contractor shall not contract for supplies or services from a debarred or suspended subcontractor on any public contract.

(i) The secretary of administration shall by regulation drawn up in consultation with each secretary and the commissioner provide for, upon the request of any secretary or the commissioner the timely commencement by, the removal to, or consolidation at the executive office of administration and finance of debarment or suspension proceedings. Such regulations also shall provide that the contractor against whom debarment or suspension proceedings have been initiated may apply to the secretary of administration for consolidation of such proceedings at the executive office of administration. Such proceedings shall be conducted by the secretary of administration or his designee in accordance with the provision of this section.

Added by St.1991, c. 550, § 1.

Historical and Statutory Notes

1991 Legislation

St.1991, c. 550, § 1, was approved Jan. 9, 1992.

Section 5 of St.1991, c. 550, provides:

"The provisions of this act shall apply only to contracts solicited or entered into after the effective

date of this act. Any renewal, extension, modification, or exercise of any option under any contract after the effective date of this act shall be subject to the provisions of this act. Any debarment imposed prior to the effective date of this act shall continue in effect."



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February 17, 1993

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DeNUCCI SAYS VENDOR'S SCHEME COSTS COMMONWEALTH OVER \$1 MILLION

State Auditor A. Joseph DeNucci reported today that WORK, Inc., a non-profit, human service vendor based in Quincy and under contract with the departments of Mental Health and Mental Retardation, overcharged the Commonwealth at least \$1 million over a four-year period. The vendor accomplished its scheme through a series of undisclosed, related party transactions with corporations established to inflate costs and overcharge the state.

DeNucci's audit, covering the period from July 1, 1987 to June 30, 1991, disclosed that WORK's president and executive vice-president also ran WORK's three related companies -- R.E.A.L. Services, Inc. (REAL), Program Management Services, Inc. (PMSI), and Consolidated Products and Services, Inc. (CP&S). These two individuals were also actively involved in a fourth related entity, Friends of Work, Inc., which served as WORK's fundraising organization. The president and executive vice-president of WORK received salaries from WORK, as well as consulting fees from these related companies, amounting to \$115,000 and \$114,029, respectively, in fiscal year 1991. During the audit period, WORK purchased more than \$3 million in services from its three related companies. Over \$2 million of this total was spent without any documented bid process.

"The people who ran WORK were also making policy for these related corporations," explained Auditor DeNucci. "These relationships were intentionally concealed and created the conditions that enabled the vendor to overbill the state."

According to the audit, WORK's rental of property from one of its related companies, REAL, resulted in WORK being overpaid at least \$616,974 by the state. Virtually all of REAL's property is leased by either WORK or one of its other two related companies. In addition, transportation services provided to WORK by one of its other related companies, PMSI, led to state overpayments of at least \$105,526. The arrangements for these services were made without any evidence of competitive bids being sought. Furthermore, WORK's acquiring of group health insurance for its employees through its third partner, CP&S, resulted in state overpayments of \$178,661. CP&S, supposedly started to provide employment to the handicapped, has generated a surplus totalling this amount since it began administering this self-insurance plan.

WORK/DeNucci/2-2-2

Also, WORK paid approximately \$149,000 of utility and common costs that should have been paid by CP&S. As a result, state funds that were paid to WORK for care of the handicapped were diverted to CP&S.

Moreover, the DeNucci audit revealed that state funds were used to pay WORK's president more than \$50,000 in salaries, fees, and benefits while he was taking a sabbatical. On other occasions, the president's salary was paid with state funds while he was actively representing other corporations. WORK reported that the president was a full-time employee during this period. Furthermore, WORK's executive vice-president represented CP&S at a conference in Europe during May 1991 while he was on WORK's payroll. State funds should not have been used to reimburse either of these officials when they were not representing WORK.

DeNucci's audit also disclosed that related party transactions were commonplace among the corporations. At least 12 of 29 board members were involved in financial transactions with one or more of the corporations. However, none of this information was reported to various state and federal agencies, as required.

In addition, the audit determined that WORK misled the Commonwealth about charging two vehicles -- a 1984 BMW and a 1987 Lincoln Continental -- used by WORK's president and vice-president to state contracts. WORK informed the Department of Mental Retardation that it would no longer be charged for these cars. However, WORK then sold the vehicles in 1987 to PMSI and the two WORK officials continued to use either these cars or replacement vehicles right into fiscal year 1992 with expenses covered by state funding. It was further noted that WORK's executive vice-president received a \$7,800 annual vehicle allowance from the state for his personal car. At the time of the audit, this car was registered in New Hampshire.

"This report shows that non-disclosure of related party transactions is a routine and accepted way to conduct business with the Commonwealth," stated DeNucci. "There is no doubt that the intention of WORK and its affiliates was to deceive the state for their own benefit."

"These related party transactions diverted state funds that should have benefitted the Commonwealth's most vulnerable citizens. Instead, it fell into private hands for personal gain," concluded DeNucci.



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EXECUTIVE SUMMARY

WORK, INC.
(92-6005-9)
February 17, 1993

I. SUMMARY OF MAJOR AUDIT RESULTS

This audit of Work, Inc., a non-profit human services vendor in Quincy, covers the period from July 1, 1987 to June 30, 1991. During the audit period, WORK received \$24,920,707 in revenue -- \$14,552,878 from contracts with the Commonwealth.

Our audit uncovered over \$1 million in overpayments made by the Commonwealth to WORK due to undisclosed, non-arm's length transactions. The audit disclosed that WORK's President and Executive Vice-President also made business decisions for related companies: R.E.A.L Services, Inc. (REAL); Program Management Services, Inc. (PMSI); and Consolidated Products and Services, Inc. (CP&S). They also were actively involved with WORK's fund-raising organization, Friends of Work, Inc.

Specifically, the audit found an overpayment of \$616,974, made by the Commonwealth to WORK for property rented from REAL. The audit noted that WORK's President and Executive Vice-President each received annual payments of \$5,000 from REAL -- recently increased to \$13,000 each. Also, WORK paid PMSI almost \$941,000 for various transportation services without the benefit of formal contractual arrangements -- directly resulting in overpayments totaling almost \$107,000 made by the Commonwealth. Again, WORK's President and Executive Vice-President received additional consultant-related annual payments, this time from PMSI, totaling \$8,000 each during fiscal year 1989, and \$13,000 during fiscal years 1990 and 1991. Further, health insurance purchased by WORK through CP&S resulted in the Commonwealth's overpayment of at least \$179,000. Also, WORK paid up to \$149,000 of CP&S's utility bills with state money.

In other areas, over \$50,000 was paid by the Commonwealth to the President of WORK -- while he was on sabbatical. Also, WORK's Executive Vice-President was also compensated with state money for a European business trip made on behalf of CP&S. Additionally, 12 of the 29 board members and officers of WORK were directly involved in related-business-operations with various corporations. Further, once WORK's President and Executive Vice-President learned that the state would no longer reimburse them for the use of a BMW and a Lincoln Continental, both cars were sold to PMSI, enabling PMSI to bill the state for operating costs -- while both vehicles were still driven by WORK's President and Executive Vice-President. Although WORK's Executive Vice-President eventually stopped driving the Lincoln Continental, he continued to receive a monthly payment of \$650 towards the use of his personal car, which was registered in New Hampshire.

WORK, INC.
(92-6005-9)

The audit points out the WORK regularly conducts business with the state through related party transactions. Also, it became common for those connected with WORK (President, Executive Vice-President, board members) to benefit for services performed with and for other business-related corporations.

HIGHLIGHTS OF AUDIT RESULTS

II.a. The Rental of Property by WORK from REAL Resulted in an Overpayment of \$617,000 by the Commonwealth:

Because WORK's President and Executive Vice-President held decision-making positions in REAL, CP&S, and FMSI, questionable business transactions occurred which resulted in inappropriate overpayments by the Commonwealth. For example, 96% of all real estate owned by REAL is leased by either, WORK, FMSI, or CP&S. Any improvements made to the property by these corporations are funded with state money, and then revert back to REAL at the end of the lease period. Importantly, although REAL owns several million dollars worth of real estate, it only expended \$5,000 of its own funds for necessary repairs and maintenance costs.

This was allowed to happen because WORK's President and Executive Vice-President held positions of authority at these corporations. Both received \$5,000 each from REAL, which has since been boosted to \$13,000 -- all payments supplementing the Presidents annual salary of \$115,5000 (plus two cars), and the Executive Vice-Presidents annual salary of \$114,029 (plus a \$650 monthly car allowance). Since WORK, REAL, FMSI, and CP&S are related entities, any services performed for WORK by these corporations should have been done at the cost that WORK itself would have charged for doing the job.

b. FMSI's Provision of Transportation Services to WORK Resulted in an Overpayment of at Least \$106,000 by the Commonwealth:

The audit noted that the state overpaid almost \$106,000 in transportation services, supplied through a verbal agreement, by FMSI to WORK. WORK's President and Executive Vice-President held the positions of President and Vice-President for FMSI, receiving \$8,000 each from FMSI during fiscal year 1989, and then boosted to \$13,000 during fiscal years 1990 and 1991. Because the business relationship between WORK and FMSI was hidden from the state, the audit found that the \$106,000 in state overpayments would have been prevented through the appropriate disclosure of related business transactions.

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WORK, INC.
(92-6005-9)

- c. WORK's Acquiring of Health Insurance through CP&S and Assuming CP&S's Utility Costs Resulted in an Overpayment of at Least \$328,000 by the Commonwealth:

CP&S provided health insurance to WORK and PMSI, with all premiums covered by reimbursements from the Commonwealth. Because this plan is self-administered, CP&S operated the plan by setting premium costs that exceeded claims -- thereby generating a four-year-surplus of at least \$178,000 from state funds. The audit also noted that employees of WORK, REAL, and PMSI were listed as employees of CP&S in order to be accepted into the health plan. CP&S's retention of these diverted funds resulted in the lack of necessary services to handicapped persons. Compounding matters was that WORK paid CP&S's utility bills with state money, totaling almost \$149,000. The direct result of this inappropriate payment was that the Commonwealth subsidized the operations of CP&S through unfair and excessive costs.

Recommendation:

The audit recommended that the Division of Purchased Services calculate all overpayments made by the state to WORK, REAL, PMSI, and CP&S, and then make every effort to recover these funds. Additionally, the Division should determine if additional overpayments have been made, and document the information so that the state can be reimbursed. Further, the state should seek reimbursements from CP&S for the surplus of \$179,000 related to health insurance, and the \$149,000 in utility costs paid by WORK with state funds.

- III. The Commonwealth was Charged for the Salaries of the President and the Executive Vice-President of WORK, Inc., While They Were Actively Representing Other Corporations:

During fiscal years 1987 and 1988, the President of WORK was granted a sabbatical by the Board of Directors, yet over \$50,000 in salaries, fees and benefits were paid to him using state money. Additionally, WORK's Executive Vice-President was in Europe representing another corporation, however, he was compensated by WORK, using funds from the Commonwealth. The audit pointed out that these two examples illustrate the need for WORK's Board of Directors to clearly define the duties and responsibilities of WORK's President and Vice-President.

- IV. The Board of Directors, the Management, and the Accountant Failed to Disclose Related Party Transactions:

The audit disclosed that in addition to the related party transactions between WORK and various corporations, many other related transactions involving WORK's board members, employees, and individual corporations had not been disclosed. Specifically, 12 of the 29 board members and officers took part in financial transactions with several corporations. The audit found that these transactions were not disclosed to the Rate Setting Commission, the Division of Purchased Services, the Attorney General, and the Internal Revenue Service -- as required.

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WORK, INC.
 (92-6005-9)
 February 17, 1993

V. WORK Misled the Commonwealth about Charging the Cost of Certain Vehicles to State Contracts and Charged Twice for a Portion of One Vehicle's Cost:

WORK was informed by the DMR that it would no longer reimburse car costs for a BMW and a Lincoln Continental -- vehicles used by the WORK's President and Executive Vice-President. WORK stated that these costs would no longer be charged to the state, yet continued to do so by selling both vehicles to FMSI, with the operating costs appearing on FMSI's cost sheets. Importantly, WORK's President continued to drive the BMW, and although the Executive Vice-President stopped driving the Lincoln Continental, he received a monthly payment of \$650 in state money to operate his personal car, which was registered in New Hampshire. Also, the audit found that FMSI then purchased a new BMW for \$43,000. Payments were made by FMSI's giving a \$20,000 car allowance, an \$8,000 loan to the President, and \$15,000 received on a trade in from the old BMW.

Recommendation:

The audit recommended that the Division of Purchased Services determine an appropriate car allowance for providers doing business with the state. Importantly, the audit recommended that every effort should be made to recover these overpayments pertaining to car allowances.

CONCLUSION

WORK and its related corporations have created an environment in which related party transactions are a routine and accepted way to conduct business with the Commonwealth. The Boards of Directors of the corporations have members who either do business with one of the corporations, are directors of more than one of the corporations, or are incorporators of a related corporation.

Both the President and Executive Vice-President of WORK receive a large salary from WORK plus consulting fees from three of the related corporations. Total compensation from these sources amounted to \$115,500 and \$114,029, respectively, in fiscal year 1991, exclusive of cars and other allowances. Both have significant levels of authority within WORK and the other corporations. The result of the Boards of Directors' vesting such authority in these individuals defeated the internal controls the corporation had in place below the executive level. This authority allowed these individuals and corporations to set cost allocations and to establish the cost levels of inter-company transactions such as health benefits, transportation, and improvements made to property owned by REAL. It ultimately resulted in the diversion of state funds intended for clients to non-client uses.

The audit noted that the Division of Purchased Services has made great strides in developing and implementing safeguards directly designed to improve the accountability and controls over of all providers doing business with the Commonwealth.



A. JOSEPH DeNUCCI
AUDITOR

The Commonwealth of Massachusetts

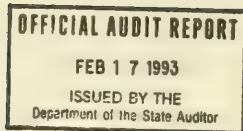
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STATE AUDITOR'S
REPORT ON CERTAIN ACTIVITIES
OF
WORK, INC.
JULY 1, 1987 TO JUNE 30, 1991



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INTRODUCTION

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On September 23, 1991, the Office of the State Auditor initiated an audit at WORK, Inc., a not-for-profit human service vendor contracting with the Commonwealth of Massachusetts, Department of Mental Retardation (DMR), Department of Mental Health (DMH), and the Massachusetts Rehabilitation Commission (MRC). During the three-year period July 1, 1988 to June 30, 1991, WORK received revenues of \$24,920,707, of which \$14,552,878 was from contracts with the Commonwealth of Massachusetts.

The objective of our examination was to assess WORK's business practices and to determine whether it complied with various applicable financial and regulatory requirements of its fiscal years 1988, 1989, 1990, and 1991 contracts with the Commonwealth.

Our audit disclosed relationships between WORK and three other not-for-profit corporations and also determined that undisclosed, related-party transactions resulted in excessive revenues to the affiliated companies through overpayments of over \$1 million from the Commonwealth to WORK for the period July 1, 1987 to June 30, 1991.

The overpayments resulted from WORK's purchasing services from related entities through a series of undisclosed, non-arm's-length transactions. The President and Executive Vice-President of WORK were the same individuals who made the operational decisions for the related entities: R.E.A.L. Services, Inc. (REAL); Program Management Services, Inc. (PMSI); and Consolidated Products & Services, Inc. (CP&S). These two individuals also made operational decisions for a fourth related entity, Friends of Work, Inc., which acts as WORK's fundraising organization.

The President of WORK has the use of two vehicles in addition to his \$115,500 annual compensation. The vehicles are reimbursed through Commonwealth contracts. WORK's Executive Vice-President receives a salary of \$114,029 and a monthly \$650 automobile allowance reimbursed through Commonwealth contracts. During the audit we noted that the Executive Vice-President's vehicle was registered in New Hampshire.

The two individuals who make the ongoing operational decisions for the four corporations are the President and Executive Vice-President of WORK. During the audit period WORK purchased in excess of \$3 million in services from the three other corporations; over \$2 million of which were acquired without any documented bid process.

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Under the State regulations in effect during the audit period, reimbursement for related party transactions was supposed to be limited to the level of cost that would have been incurred had the providers supplied the services themselves. In submitting its cost reports WORK included all expenses incurred in the purchase of services from REAL, PMSI, and CP&S without disclosing the related nature of the transactions.

The failure of WORK and its affiliated corporations to disclose these transactions between board members, management, and employees extended to tax returns, cost reports, and other filings. Therefore, we have forwarded a copy of this report to the Internal Revenue Service, the Attorney General of the Commonwealth, the Board of Public Accountancy, the Board of Bar Overseers, and the Division of Insurance.

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1. <u>Failure By WORK's President and Executive Vice-President to Adhere to Rate Setting Commission and Purchase-of-Service Regulations Concerning Disclosure of Related Party Transactions between WORK and Three Related Corporations Resulted in the Commonwealth's Overpaying WORK in Excess of \$1 Million:</u> WORK's President and Executive Vice-President held positions of authority in the related entities and coordinated the following non-arm's-length transactions between the related entities and WORK.	15
a. <u>The Rental of Property by WORK from REAL Resulted in an Overpayment of at Least \$616,974 by the Commonwealth:</u> REAL is a not-for-profit corporation that owns and leases property, most of which is leased by other not-for-profits. Virtually all of REAL's property is leased by WORK, PMSI, or CP&S. During the audit period REAL received in excess of \$990,000 (96% of REAL's rental income) from these organizations.	15
REAL has no employees; however, the President and Executive Vice-President of WORK received annual compensation of \$5,000 each in the form of consulting fees. (On July 1, 1992 their compensation had been increased to \$13,000 each.)	
Because REAL and WORK are related entities they fall within the provision of the regulations governing the reimbursement of related parties. That provision limits	

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the provider to the cost that would have been incurred had it provided the service itself. We have calculated the overpayments made by WORK for the period between July 1, 1987 and June 30, 1991 to be at least \$616,974.

- b. PMSI's Provision of Transportation Services to WORK Resulted in an Overpayment of at Least \$105,526 by the Commonwealth: Under a verbal agreement PMSI, a not-for-profit corporation, provides WORK with a number of different transportation services. During fiscal year 1991 the corporations were in the third year of a three-year verbal agreement during which WORK paid PMSI \$940,914. The entire arrangement was agreed to without any documented competitive bidding process.

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During our review we found that the President and Executive Vice-President of WORK are part of the management of both corporations. They serve as consultants to PMSI; have the titles of President and Vice-President, respectively; and received consulting fees of \$8,000 each in fiscal year 1989 and \$13,000 each in fiscal years 1990 and 1991. Both receive additional benefits from PMSI in the form of the use of vehicles and vehicle allowances.

The existence of this relationship between the corporations was not disclosed to the regulatory agencies, in violation of reporting requirements. We identified at least \$105,526 that the Commonwealth would have saved had the relationship between these entities been disclosed.

- c. WORK's Acquiring of Health Insurance through CP&S and Assuming CP&S's Utility Costs Resulted in an Overpayment of at Least \$327,661 by the Commonwealth: CP&S, a not-for-profit corporation, provides employment to handicapped individuals. Under a self-insurance plan CP&S provides group health insurance and dental coverage to its employees as well as those of WORK and PMSI. The Executive Vice-President of WORK (who is also a consultant to CP&S), along with an insurance consultant, set the premium level for all three corporations. For the four-year period ended June 30, 1991 the insurance premiums have exceeded the claims, generating a surplus of \$178,661 for CP&S. The effect has been that state funds paid to WORK for the care of handicapped individuals were diverted to CP&S.

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<p>We estimate that, for the four year-period ended June 30, 1991, WORK also paid approximately \$149,000 of utilities and common costs that should have been borne by CP&S. The effect is that the Commonwealth has subsidized the operations of CP&S through unfair and disproportionate allocation of costs.</p>	
<p>2. <u>The Commonwealth Was Charged for the Salaries of the President and Executive Vice-President of WORK, While They Were Actively Representing Other Corporations:</u> During part of fiscal years 1987 and 1988 the President of WORK was granted a sabbatical by WORK's Board of Directors. WORK was reimbursed by the Commonwealth for the salary of the President during the time he spent on sabbatical. Over \$50,000 in salaries, fees, and benefits were paid to the President during this period.</p> <p>The Executive Vice-President of WORK periodically takes trips on behalf of CP&S. In May 1991 he represented CP&S at a conference in Europe. The Executive Vice-President should not have been compensated by WORK for the time he spent representing CP&S at this conference.</p>	28
<p>3. <u>The Board of Directors, the Management, and the Outside Accountant Failed to Disclose Related Party Transactions:</u> In addition to the related party transactions between the corporations, there were many other related transactions between individual board members, management employees, and the individual corporations that were not disclosed. At least 12 of the 29 board members and officers of the corporations were involved in financial transactions with one or more of the corporations. Yet the Boards of Directors and the management of the corporations, as well as their outside public accountant, failed to disclose the extent of related party transactions on the filings with the Rate Setting Commission, the Division of Purchased Services, Attorney General, and the Internal Revenue Service.</p>	29
<p>4. <u>WORK Misled the Commonwealth about Charging the Cost of Certain Vehicles to State Contracts and Charged Twice for a Portion of One Vehicle's Cost:</u> The President and the Executive Vice-President of WORK both had the use of vehicles whose costs had been charged to WORK's contracts.</p> <p>During fiscal 1987 DMR informed WORK that DMR was no longer going to reimburse WORK for certain vehicles, specifically a 1984 BMW and a 1987 Lincoln Continental. Management of WORK informed DMR that the cost of these vehicles would no longer be included on their cost report. Based on this conversation, DMR believed it would no longer be charged for the vehicles.</p>	32

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In June 1988 these vehicles were sold to PMSI. WORK's President and Executive Vice-President have continued to use these vehicles or replacement vehicles or to receive allowances through fiscal years 1989, 1990, and 1991, and into fiscal year 1992. PMSI has included the cost of vehicles and vehicle allowances on its cost report during the entire audit period. All of PMSI's costs during the three-year period were charged either directly to DMR or to WORK.	
CONCLUSION	34
WORK and its related corporations have created an environment in which related party transactions are a routine and accepted way to conduct business with the Commonwealth. It was common practice for the corporations' board members to do business with one or more of the other corporations. A partner of the accounting firm that conducted WORK's fiscal year 1988 and fiscal year 1989 audits was a member of REAL's board and an advisory member of WORK's board. Both the President and Executive Vice-President of WORK receive a salary from WORK, plus consulting fees from the related corporations. Salary and consulting compensation from these sources amounted to \$115,500 and \$114,029, respectively, in fiscal year 1991. Both have significant levels of autonomy and authority within WORK and the other corporations. The Boards of Directors' vesting such authority in these individuals defeated the purpose of the internal controls the corporation had in place below the executive level. This autonomy and authority allowed these individuals and corporations to set cost allocations and establish the cost levels of inter-company transactions, such as health insurance, transportation, and improvements made to property owned by REAL.	34
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INTRODUCTION

Background

On September 23, 1991, the Office of the State Auditor initiated an audit at WORK, Inc., a non-profit human service provider contracting with the Department of Mental Retardation (DMR), the Department of Mental Health (DMH), and the Massachusetts Rehabilitation Commission (MRC) to provide services to mentally retarded clients who are attempting to adapt to life in the community. On July 16, 1970 WORK was incorporated as a not-for-profit corporation pursuant to Massachusetts General Laws, Chapter 180.

The Commonwealth of Massachusetts uses private vendors to provide social, rehabilitative, and training programs for many clients in need of human services. Individual state agencies are responsible for procuring these services for the clients under their care.

Vendors that contract with the agencies for such services had their rates of reimbursement determined by the purchasing agencies and approved by the Commonwealth's Rate Setting Commission. On July 1, 1990 the Division of Purchased Services assumed responsibility for implementing and coordinating a system of procurement, selection, pricing, contract administration, program monitoring and evaluation, compliance, and post audit for any department, board, or commission which procures social service programs. The Division of Purchased Services promulgated new regulations, designed a new cost reporting system, and developed a new pricing methodology. Although the regulations remained basically the same, the cost-reporting document was changed from an unaudited information-gathering document to a set of financial statements and supplemental schedules entitled the "Uniform Financial Statement and Independent Auditor Report" (UFR). As such, it did not require disclosures with yes and no answers covering ancillary information within the report that

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had been required in the unaudited RSC 1100 cost report in previous years. Many of the issues raised in this report can be traced to the inadequacies of this RSC 1100 cost report and its non-utilization by the purchasing agencies.

In this report we discuss four corporations and the nature of their relationship with each other and the Commonwealth. A fifth corporation, FRIENDS, is also referred to but does not play a significant role in this report.

Between July 1, 1988 and June 30, 1991 WORK received \$24,920,707 in revenues, of which \$14,552,878 was from contracts with the Commonwealth. As a human service provider, WORK is required to file an annual UFR with the Division of Purchased Services.

In meeting its contractual obligations WORK relies on services provided by several other not-for-profit corporations. Program Management Services, Inc. (PMSI), which was incorporated with the Secretary of State on June 7, 1983, received \$3,044,133 from DMR and an additional \$940,914 from WORK for transportation services provided to them during the same three-year period.

R.E.A.L. Services, Inc. (REAL) filed its corporation papers with the Secretary of State on April 30, 1976. REAL is a not-for-profit real estate company that acquires, holds, and leases real estate. Virtually all of REAL's earned income is derived from renting property to WORK, PMSI, and CP&S. During the three-year period REAL's records indicate that it received \$996,833 of its total rental income, over 96%, from these three corporations, the balance being earned from another not-for-profit corporation. REAL has no employees.

Consolidated Products and Services, Inc. (CP&S) is a not-for-profit corporation that filed its corporation papers with the Secretary of State on June 11, 1981. CP&S employs handicapped individuals in the manufacturing and

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packaging of various items. It also provides health insurance, on a self-insured basis, for some of its employees as well as employees of WORK and PMSI.

Each of the corporations has its own Board of Directors, which meets periodically to discuss operations and occasionally to vote on issues before it. However, the individuals, who make the day-to-day decisions for the four corporations, are the President and Executive Vice-President of WORK. They also hold the same management titles at PMSI and CP&S and are both paid as consultants by PMSI, CP&S, and REAL.

WORK maintains an ongoing business relationship with all three corporations. WORK is a major client in REAL's real estate operation, obtains virtually all of its outside transportation services from PMSI, and acquires health insurance for its employees from CP&S.

Compensation of these two individuals

The President and Executive Vice-President of WORK consistently received compensation from the four related corporations. For example, in fiscal year 1991 these two individuals, received a total of \$115,500 and \$114,029, respectively, in salary and consulting compensation.

<u>Company</u>	<u>President</u>	<u>Executive Vice-President</u>
WORK	\$ 82,500	\$ 81,029
PMSI	13,000	13,000
CP&S	15,000	15,000
REAL	<u>5,000</u>	<u>5,000</u>
	<u>\$115,500</u>	<u>\$114,029</u>

The President also has the use of two PMSI vehicles, and the Executive Vice-President receives a vehicle allowance of \$7,800 per year from PMSI. Additional benefits received by both individuals include life insurance, an annuity, and health insurance.

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The key management personnel of WORK and the related corporations are primarily responsible for the activities outlined in this report. However, the Boards of Directors of these corporations and the Commonwealth of Massachusetts purchasing agencies and RSC were nevertheless still responsible for having created an environment that allowed these activities to exist. The outside public accountant for all of these entities is also responsible for not having made certain disclosures in the audited financial statements, such as the presence of the accounting firm on the board of some of the corporations and members of the firm serving as officers in some of the corporations.

Audit Scope, Objectives, and Methodology

The scope of our audit included an examination of the books and records of WORK covering the four-year period July 1, 1987 through June 30, 1991. In the course of the examination it was necessary to expand the scope to a review of the financial records of four related corporations, REAL, PMSI, CP&S, and FRIENDS. We made our examination in accordance with generally accepted government auditing standards and, accordingly, included such tests of the records and such other auditing procedures as we considered necessary.

The objective of our examination was to assess WORK's business practices and to determine whether it complied with various applicable financial and regulatory requirements of its fiscal years 1988, 1989, 1990, and 1991 contracts with the Commonwealth.

Subsequently, this objective was expanded to determine (1) the nature of the relationship between WORK and four corporations doing business with WORK, (2) whether there were any related party, not at-arms-length, transactions between WORK and the other corporations, and (3) if so, whether an overpayment to WORK had resulted from these relationships.

In order to meet these objectives we examined the management structure of the organizations and the transactions between the corporations. In addition to examining the management structure, we reviewed the Articles of Organization and bylaws for all five corporations and the filings with the Rate Setting Commission, Division of Purchased Services, the Attorney General's Office, and the Internal Revenue Service.

We also reviewed the minutes of the Boards of Directors of the four corporations when they were made available to us. Whenever we detected unusual or questionable transactions, we attempted to get supporting documentation such as invoices, cancelled checks, and contracts. However, it was not always possible to obtain such documentation because some of the agreements between the corporations were verbal and documented board authorizations and approvals were scarce.

We also interviewed the President and Executive Vice-President of WORK to determine how the corporate decision-making process worked and to determine the liability and responsibility for those areas covered by verbal agreements. As noted, these two individuals also serve the other three corporations and are compensated by them.

Our audit covered the four-year period ended June 30, 1991, and in certain instances, financial information from fiscal years prior to 1988 and subsequent to 1991 has been included to provide a perspective on the historical nature of certain activities.

Determination of Relationships Between the Corporations

The Commonwealth of Massachusetts purchase-of-service system relied exclusively on the provider and its accountant to make the determination and disclosure of related party. If the provider or their accountant failed to

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make the disclosure, the system was incapable of capturing such omissions or misrepresentations because disclosure was limited to the RSC 1100 Cost Report.

Currently the Division of Purchased Service's regulations require five separate related party disclosures in the contracting process. These disclosures are affirmed, under the penalty of perjury, by representatives of the board of directors, management, and the independent accountant.

This system may minimize the number of providers that do not disclose related party transactions or other relationships; however, as in the past, some providers may still not comply with the regulations.

During the three-year period July 1, 1988 to June 30, 1991 WORK received \$14,552,878 from agencies of the Commonwealth, of which over \$3.5 million (see Exhibit I) was paid to three affiliated corporations -- REAL, PMSI, and CP&S -- exclusive of interest paid on inter-company loans. During the same period, PMSI received an additional \$3,044,133 directly from DMR. Both WORK and PMSI filed cost reports with RSC in 1988 and 1989 and the UFR with the Division of Purchased Services in 1990 and 1991 and are required to disclose related party transactions.

In the submission of these filings, WORK included all expenses incurred in its purchase of services from REAL, PMSI, and CP&S without disclosing the related nature of the transactions. Subsequent to the period of audit and during the ongoing audit, WORK formally notified DPS that all five corporations were related parties; however, it did not address the financial transactions and other relationships that directors and officers had with other companies they had interests or ownership in. This disclosure was apparently because of the ongoing audit and the new regulations. Under the regulations in effect during the audit period, reimbursement for related party transactions were limited to the level of cost that would have been incurred

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had the providers supplied the service themselves.

In determining whether or not these entities were related, we examined the definition of related party under generally accepted accounting principles (GAAP), 114.5 Code of Massachusetts Regulations (CMR) 3.00, 808 CMR 1.00, and the Internal Revenue Service Code. All of these sources include in their definition common ownership, affiliation, or control as a test of relationship. Each criterion stands on its own; a determination of relationship under anyone of these standards is enough to make such a determination. In addition, a related party situation exists when the management of one entity has the ability to significantly influence another. GAAP warns that "one cannot assume that a related party transaction is consummated in the same manner as an arm's-length transaction, since free market competition is not the basis for related party transactions." Generally Accepted Auditing Standards Statement No. 45 further requires that the independent auditor is responsible for reporting on nondisclosures of related party transactions and relationships.

Prior to April 17, 1991, 114.5 CMR 3.00 was the regulation governing reimbursement for WORK's contracts with the Commonwealth. According to that regulation, which was in effect for the most of the audit period, related party is defined as:

A person or organization which is associated with, has control of, or is controlled by the operating agency or any director, stockholder, partner, or administrator of the operating agency by common ownership or control or in a manner specified in sections 267(b) and (c) of the Internal Revenue Code of 1954 as amended, . . .

This regulation also states that:

Control exists where an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

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On April 17, 1991, new DPS regulations went into effect with an expanded definition of related party.

An area of concern in the regulatory process is any relationship between the provider and its suppliers. Therefore, any related transaction must be disclosed on the financial statements, cost reports, and other filings. The reasons for this concern are obvious and clearly stated under generally accepted accounting principles. The Financial Accounting Standards Board of the American Institute of Certified Public Accountants (AICPA) defines a related party as:

Principal owners of the enterprise; its management; members of the immediate family of the principal owners of the enterprise and its management; and other parties with which the enterprise may deal if one party controls or can significantly influence the management or operating policies of the other to an extent that one of the transacting parties might be prevented from fully pursuing its own separate interests. Another party is also a related party if it can significantly influence the management or operating policies of the transacting parties and can significantly influence the other to an extent that one or more of the transacting parties might be prevented from pursuing its own separate interests.

Each not-for-profit corporation has a Board of Directors, and, with the exception of REAL and CP&S, there are currently no common board members. Each of the corporations, according to their articles of incorporation have some commitment to handicapped individuals, and all have worked in concert over the years towards this purpose. The Executive Vice-President of WORK agrees that there is an affiliation, but only to the extent that the four corporations worked together towards a common goal. The Executive Vice-President steadfastly maintains that the corporations were unrelated prior to April 17, 1991, when the Division of Purchased Services redefined related party within 808 CMR 1.00. He stated that all we would find was that the corporations "did business with one another, and borrowed money from one another."

Our review of the interaction between the corporations found relationships that went far beyond that described by the Executive Vice-President. Further, WORK has the ability to significantly influence the other corporations and to manipulate its own financial picture through its interactions with these companies. We found that the Executive Vice-President had the authority to influence all of the corporations, and he repeatedly demonstrated his authority, influence, and control over them.

Our determination of control was based on documentation found in the books and records of the corporations and on the influence exercised by the President and Executive Vice-President in their authority to (1) sign notes and negotiate loans, (2) sign checks, (3) supervise employees, (4) negotiate and sign leases, (5) approve the expenditure of funds, and (6) execute transactions between the corporations.

(1) Sign notes and negotiate loans: According to the President, both he and the Executive Vice-President receive their authorization from the boards, independent of one another. He has the authority to make decisions that the Executive Vice-President is not empowered to and conversely the Executive Vice-President has authority in areas that the President does not. The President stated that he did not believe that he had the authority to borrow funds, negotiate loans, or sign notes in the name of the various corporations. He further stated that if he in fact had such authority, he was unaware of it and had never exercised it.

We found that REAL maintains a checking account, which is used to pay for certain repairs and improvements and to make loans to the various corporations. Both the President and the Executive Vice-President are authorized to draw on this account. Whether or not the President ever exercised his authority is immaterial. The test of relatedness centers on the

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ability and authority to influence.

The Executive Vice-President, on the other hand, routinely signed notes and loans. For example, in June 1988 WORK sold a number of vehicles, some of which were acquired by PMSI. The vehicles purchased by PMSI were financed by a bank. The notes were signed by the Executive Vice-President of WORK as the Executive Vice-President of PMSI.

On September 1, 1987 the Executive Vice-President paid for a pickup truck for WORK, which was purchased from a dealership. This vehicle was paid for with a check drawn from REAL and set up as a loan payable to REAL from WORK. The sales agreement was signed by the Executive Vice President on behalf of WORK, and the financing was obtained by the Executive Vice-President of WORK who drew the funds from REAL's account.

(2) Sign checks: Both the President and Executive Vice-President have the authority to sign checks for WORK, PMSI, CP&S, and the loan account for REAL.

(3) Supervise employees: REAL has no employees, but both the President and Executive Vice-President are consultants to REAL and are currently paid \$13,000 a year. The President in his interview stated that he plays no role in the day-to-day supervision of employees, as each corporation has its own internal management. He is, however, listed as the General Manager on the letterhead of CP&S, and the Executive Vice-President is listed as the Assistant Manager. The Executive Vice-President has performed employee evaluations, including the evaluation of the Program Director at CP&S. In our interview with the Program Director of PMSI, he deferred any questions regarding administrative employees, management policies, cost allocations, and maintenance employees to the Executive Vice-President of WORK.

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(4) Negotiate and sign leases: The Executive Vice-President has negotiated and signed leases with REAL on behalf of CP&S, PMSI, and WORK.

(5) Approve the expenditure of funds: The President stated, with qualification, that although he may have the ability to approve expenditures, this was not an activity in which he normally participated. The Executive Vice-President, on the other hand, routinely approves invoices for CP&S, PMSI, and WORK. On occasion the Executive Vice-President will incur expenses on behalf of one corporation, charge them to a credit card of another corporation, then authorize the reimbursement from one corporation to the other. The Executive Vice-President borrows and repays loans between the corporations and accesses the REAL loan account on behalf of the corporations. On several occasions both the President and Executive Vice-President have charged personal items to corporate accounts and subsequently had the money deducted from their salaries.

The Executive Vice-President's position was so strong that in June 1988 he was "requested" by the board of REAL not to sign purchase-and-sale agreements until after the board had approved the transaction. Presenting a signed purchase-and-sale agreement to the board clearly indicates the level of influence that the Executive Vice-President, or WORK, had within REAL.

(6) Execute transactions between corporations: The President and Executive Vice-President have the ability to execute loans on behalf of the corporations. They also have the ability to allocate costs between the corporations or have WORK assume those costs to the benefit of the other corporations.

In addition, the Executive Vice-President, along with an insurance consultant, set the premium level to be charged to WORK, PMSI, and CP&S for employee health insurance. The Executive Vice-President has the ability to

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approve these premiums on behalf of WORK. There is no mention of pricing these premiums in any of the board meeting minutes made available to us. The insurance premiums ranged between 20% and 30% of the gross revenues of CP&S during the audit period; yet the entire process -- from choice of carrier, to the setting of the premium, to the payment of the invoices -- all falls within the scope of the Executive Vice-President's role within this group of corporations, without any documentable concern or discussion by any of the boards.

The inter-relationship between the corporations was clearly demonstrated in January 1991, when a Marketing Director was hired, ostensibly as an employee of WORK. This individual had her salary funded by FRIENDS, was presented to the employees of WORK as the Marketing Director of that corporation, received her check from PMSI, and was covered for health insurance by CP&S.

A further illustration of the inter-relationship between WORK and the other corporations is in WORK's providing bookkeeping and other administrative services to all of the corporations and allocating the cost of property insurance and other common costs to the other corporations. This is noteworthy, as prior to fiscal year 1991 only a fraction of the costs were actually charged to the other corporations.

Based on the evidence, the President, the Executive Vice-President, and WORK had the power to significantly influence or direct the action and policies of the other corporations and, as members of management or as consultants to all four corporations, had the authority and power to significantly influence each of the corporations individually. Therefore, the WORK organization and its President and Executive Vice-President are related parties to the other corporations, and REAL, PMSI, and CP&S are all related to

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each other as well as to WORK. As such, transactions between these corporations should have been disclosed on the cost reports filed with the Commonwealth and should have been disclosed on the financial statements reported on by their accountant. Since REAL and CP&S do not contract directly with the Commonwealth, and since their relationship with WORK was not disclosed, they were able to function outside of the channels of regulatory review by the Commonwealth.

The result of this ability to influence the financial performance of the corporations is evident in the following schedule. It shows the fund balance of the two corporations (CP&S and REAL) free from financial regulation increasing by \$374,109 and the fund balance of PMSI increasing by \$121,198 (over \$100,000 of which can be traced to the agreement with WORK). During the same time frame the fund balance of WORK dropped by \$105,614.

Comparison of Fund Balances 1988-1991

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>Change</u>	
					<u>\$</u>	<u>%</u>
WORK	\$494,937	\$562,970	\$477,248	\$389,323	(105,614)	(21)
PMSI	\$ 1,912	\$ 33,052	\$ 96,718	\$123,110	121,198	643
CP&S	\$229,740	\$317,052	\$259,817	\$265,613	35,873	16
REAL	\$401,199	\$485,873	\$627,845	\$739,435	338,236	84

Commonwealth funds intended for services to be provided by WORK for handicapped clients are being diverted to corporations that are outside of normal regulatory review. This diversion ultimately resulted in a depletion of the funds for services to other handicapped individuals throughout the Commonwealth.

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The undisclosed interrelationships and transactions by and between the board members and the corporations warrants further review and remedy. We are therefore forwarding this report to the Internal Revenue Service, Board of Public Accountancy, Board of Bar Overseers, Attorney General of the Commonwealth, the Division of Insurance, the Division of Purchased Services, the Department of Mental Retardation, and the Executive Office of Health and Human Services.

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AUDIT RESULTS

1. Failure by WORK's President and Executive Vice-President to Adhere to Rate Setting Commission and Purchase-of-Service Regulations Concerning Disclosure of Related Party Transactions between WORK and Three Related Corporations Resulted in the Commonwealth's Overpaying WORK in Excess of \$1 Million

WORK's President and Executive Vice-President held positions of authority in the related entities and coordinated the following non-arm's-length related party transactions between the related entities and WORK.

- a. The Rental of Property by WORK from REAL Resulted in at least a \$616,974 Overpayment by the Commonwealth: REAL is a not-for-profit corporation that owns and leases property, most of which is leased to other not-for-profits. Virtually all of REAL's property is leased by WORK, PMSI, or CP&S. During the three-year period ended June 30, 1991 REAL received in excess of \$990,000 (96% of REAL'S rental income) from these organizations.

According to records at the Secretary of the Commonwealth's Office, REAL was formed on April 30, 1976 as a not-for profit corporation "to provide physical facilities to accommodate the rehabilitation, education, and living services supplied to handicapped citizens of the Commonwealth."

REAL has no employees, but the President and the Executive Vice-President of WORK receive annual compensation of \$5,000 each in consulting fees. (On July 1, 1992 their compensation had been increased to \$13,000 each.)

REAL's first real estate transaction was the purchase of property at 3 Arlington Street, Quincy, Massachusetts, for \$180,000 in 1976. The current Arlington Street complex consists of three separate parcels; this was the first of the three acquired by REAL. Between 1976 and June 30, 1991 the holdings grew to include 13 sites at a total cost of \$2,314,075. Documents on file at the Attorney General's Office indicate that REAL received \$401,400 in

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rental income during fiscal year 1991 from the following sources:

WORK, INC.	\$350,900
CP&S	30,000
PMSI	15,000
Other	<u>5,500</u>
	<u>\$401,400</u>

We calculated \$359,500 as the rent paid by the related corporations to REAL which is \$41,900 less than that reported by REAL.

WORK leases space within the Arlington Street complex as well as a number of other program sites. Both CP&S and PMSI lease space within the Arlington Street complex, which includes three contiguous parcels located between Arlington and Fayette Streets in Quincy. A complete list of the properties rented from REAL and the fiscal year 1992 annual rents appear in Exhibit II.

During the three-year period July 1, 1988 to June 30, 1991 virtually all of REAL's rental income was generated from renting property to WORK, PMSI, and CP&S. Using the audited financial statements of REAL and additional information available in the leases, we calculated rental income for the period as follows:

Rents Received by REAL
July 1, 1988 to June 30, 1991

	<u>Amount</u>	<u>Percent</u>
WORK	\$ 891,833	86.1
PMSI	45,000	4.4
CP&S	60,000	5.8
Other	<u>38,394</u>	<u>3.7</u>
	<u>\$1,035,227</u>	<u>100.0</u>

As noted above, over 86% of REAL's rental income is generated by WORK. The Financial Accounting Standards Board of the AICPA defines a major customer as one who is responsible for more than 10% of the revenues generated by an enterprise. The AICPA board requires that the existence of a major customer and the reliance that the company has on that customer be disclosed on the

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on the audited financial statements of the company, as well as the existence of the related party transactions. However, REAL's accounting firm failed to disclose any of this information in its report on the financial statements for fiscal years 1989 and 1990, nor did it disclose the position of one of the firm's partners as an advisory member of WORK's Board of Directors.

In a normal arm's-length transaction, one would expect WORK, as a major tenant, to have the ability to negotiate favorable terms in its leases. However, this has not been the case. In fact, as discussed below, the relationship appears to have been structured to benefit REAL at the expense of WORK and, in effect, the Commonwealth.

- o In 1978 WORK assumed the remaining portion of the South Shore Rehabilitation Center's lease with REAL. At the time the lease had eight years remaining, and the annual lease payments were \$29,400 per year. On January 1, 1979 an additional lease was entered into for 22 Fayette Street at an annual rent of \$45,600, resulting in a total annual rent for the complex of \$75,000.
- o In 1981 the lease was rewritten for a new ten-year period. Included in this lease were provisions requiring REAL to make improvements, including a new heating plant and energy efficient windows. However, in 1981 WORK, not REAL, installed a heating system and windows.
- o In 1985 the lease was again rewritten for a new ten-year period at \$69,000 per year. There were no concessions made by REAL at the time the lease was rewritten. Between July 1, 1981 and June 30, 1986 WORK made in excess of \$230,000 in leasehold improvements to the Arlington Street complex. Total rents for the property during this period were \$369,000.
- o In 1990, with six years remaining on it, the lease was again rewritten. This time the rent increased from \$69,000 per year to \$119,580 per year. Again no concessions or improvements by REAL were included in the lease negotiated by WORK.

WORK was responsible for 86.1% of REAL's rental income during the period July 1, 1988 to June 30, 1991, yet consistently allowed a long-term lease to be renegotiated at a higher rent at the approximate mid-point of its term.

Extraordinary improvements have also been made to the real estate by WORK, all of which revert to REAL at the termination of each lease. Between fiscal

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years 1989 and 1991 REAL, the owner of several million dollars worth of real estate, made total repairs of less than \$5,000 to all of its properties. The balance of the repairs and maintenance were paid by the tenants. We believe that net-net leases (in which the tenant pays all costs associated with the property), combined with large increases in rent, have benefited the landlord at the expense of the tenants. Had WORK paid for the improvements and repairs while paying a lower rent, or had REAL received a significant increase as the result of improvements it had made to the property, there would be less of an issue. However, in this case WORK has not only experienced large rental increases, it has also made the significant property improvements not normally associated with rental increases of this magnitude.

We do note, however, that the Executive Vice-President and President are consultants to REAL and that the Executive Vice-President represents WORK in its negotiations with REAL. During critical negotiation periods prior to the 1986 and 1990 leases, there was no mention of the transactions in the WORK board minutes and no documented votes approving these leases or many other transactions involving major WORK commitments.

In 1988, when WORK was planning on purchasing the Arlington Street complex from REAL, board discussions indicate some concern with the financial impact on REAL. There was no discussion on the recovery of WORK's investment in the real estate, nor was there any documented concern that WORK would be paying twice for these improvements. In an arm's-length transaction the recovery of WORK's investment would have been of far greater concern than the eventual financial impact on REAL, the seller. This lack of concern may be explained by the board minutes that state: "WORK, Inc. will now purchase the Arlington and Fayette Street Property from REAL services and the cost will be passed on

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to the state."

Real estate decisions were based on the fact that WORK receives Commonwealth funding and its costs are reimbursable under Commonwealth contracts. The relationship between WORK and REAL is clearly established by the practices and policies of both corporations, especially the influence demonstrated by the Executive Vice-President. This relationship was not disclosed to the funding agencies in the cost reports filed by WORK, nor was it disclosed to banks, potential donors, and other interested parties in the financial statements, even though a partner of WORK and REAL's accounting firm was Treasurer of REAL and an advisory member of the WORK board.

REAL and WORK are related entities and, as such, fall under the provisions of the regulations governing the reimbursement of related parties. That provision limits the reimbursement to the cost that a vendor would have incurred had it provided the service itself. We have calculated the overpayments made by WORK for the period July 1, 1987 to June 30, 1991 to be at least \$616,974, as shown below. (The calculation is included in Exhibit III.)

Fiscal Year 1988	\$ 66,259
Fiscal Year 1989	159,552
Fiscal Year 1990	185,463
Fiscal Year 1991	<u>205,700</u>
	<u>\$616,974</u>

The acquisition of real estate by REAL took place over a number of years. Regulations governing the compensation for property, whether it be owned or leased by a related party, differed depending on the regulations in effect at that time. The difference was generally in the length of useful life allowed by the regulatory authority for purposes of reimbursement. In our calculation of overpayments we utilized a useful life of 27.5 years, which is more generous than that allowed under the regulations. In addition, a full year's

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depreciation was included during the year of acquisition. Furthermore, in computing the above overpayment we took into consideration rents paid by PMSI and CP&S.

The regulations also allow for reimbursement for mortgage interest. The actual rates paid by REAL were included in the overpayment calculation. Interest rates were determined from either the information recorded at the Registry of Deeds or information included in the notes to the financial statements. Interest and principal balances were calculated, as needed, by using the same information. Interest was allowed on the refinancing only to the extent that principal would have been unpaid at that time under the original financing structure.

Capitalized improvements made to the property in the early years had been combined for all sites on the Internal Revenue Form 990. As a result, we considered this class of asset, independent of the location of the expenditure. A useful life of 20 years was assigned to this category and depreciation was allowed in our reimbursable cost calculation.

In summary, reimbursable costs for property leased from REAL included depreciation on real estate acquisitions, less land value; depreciation on improvements; and mortgage interest adjusted for additional funds generated by refinancing, and did not include adjustments for consulting fees and other funds paid to, or for, the President and Executive Vice-President of WORK.

Because all operating costs were paid by the tenants, there was no allowance included in this calculation for such items such as insurance and repairs.

Recommendation: The Division of Purchased Services should calculate the overpayments made to REAL and take whatever regulatory steps are necessary to expedite the recovery of those funds by the purchasing agencies. (Specific

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recommendations regarding recovery are included later in the Conclusion section of this report.)

b. PMSI's Provision of Transportation Services to WORK Resulted in an Overpayment of at Least \$105,526 by the Commonwealth: Under a verbal agreement PMSI, a not-for-profit corporation, provides WORK with a number of different transportation services. During fiscal year 1991 the corporations were in the third year of a three-year verbal agreement during which WORK paid PMSI \$940,914. The entire arrangement was agreed to without any documented competitive bidding process.

During our review we found that the President and Executive Vice-President of WORK are part of the management of both corporations. They serve as consultants to PMSI; have been given the titles of President and Vice-President, respectively; and received consulting fees of \$8,000 each in fiscal year 1989 and \$13,000 each in fiscal years 1990 and 1991. Both receive additional compensation from PMSI in the form of vehicles and vehicle allowances.

The existence of this relationship between the corporations was not disclosed to the regulatory agencies, in violation of reporting requirements. We identified at least \$105,526 that the Commonwealth would have saved had the relationship between these entities been disclosed.

This amount was determined using the income and expense information included in the RSC 1100 cost reports and UFRs. Since the transactions were not identified as related party transactions, no adjustment was made by the Rate Setting Commission or DPS. These excessive revenues do not include funds paid to the President and Executive Vice-President of WORK, nor does it make an adjustment for the vehicles or vehicle allowances they received.

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PMSI filed corporation papers with the Secretary of the Commonwealth on June 7, 1983. Two of the three original incorporators of PMSI were the President and Executive Vice-President of WORK. The President was also the Treasurer of the organization at its inception. Both of these individuals are currently consultants to PMSI and receive annual compensation of \$13,000 each.

PMSI has an agreement to provide WORK with such services as transporting clients from their residences to and from WORK programs and employment sites and leasing vehicles to WORK that are permanently assigned to program sites. Drivers are provided by PMSI for the transportation services, but some of the drivers are also employees of WORK.

PMSI has two categories of drivers. The first category works only for PMSI and provides virtually all of the transportation to WORK and other customers. The second category drives clients to and from the job sites. Upon arrival at the job site the drivers of the second category become the site supervisors for WORK; when the shift is over they become employees of PMSI again and drive the clients back to WORK or their residences. There is no document that outlines when the employees are in the employ of PMSI and when they are responsible to the management of WORK.

Furthermore, there is no written contract between WORK and PMSI that outlines the responsibilities of both parties. There is no written standard against which performance can be measured or invoices can be compared for accuracy and appropriateness. Moreover, there are no safety standards, no vehicle standards, or performance guarantees that are documented between these corporations. Invoices are submitted on a monthly basis and paid without any traceable approval process, and the detail submitted with the invoice is sometimes done in pencil. There is therefore no assurance that the amounts being paid have been reviewed by the management of WORK to determine if the

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services were in fact provided and were at the proper cost.

During fiscal year 1991 the two corporations were in the third year of a three-year verbal agreement, during which WORK paid PMSI \$940,914. The entire arrangement was agreed to without any competitive bidding process. There is therefore no assurance that the transportation services were obtained at the most reasonable cost for the Commonwealth. According to the Division of Purchased Services, there is no current regulatory requirement for WORK to put subcontracts for transportation services out to bid. However, there is and has been a requirement to disclose related party activity and a limitation on the allowable reimbursement for such transactions.

During our review we found that the President and the Executive Vice-President are part of the management of both corporations. Although there are no direct links at board level between WORK and PMSI, as is documented throughout this report the links are very strong at the management level. Management is defined by the AICPA in its publication as:

Persons who are responsible for achieving the objectives of the enterprise and who have the authority to establish policies and make decisions by which those objectives are to be pursued. Management normally includes members of the board of directors, the chief executive officer, chief operating officer, vice presidents in charge of principal business functions (such as sales, administration, or finance), and other persons who perform similar policy making functions. Persons without formal titles may be members of management.

As noted earlier, both the President and the Executive Vice-President of WORK serve as consultants to PMSI; have been given the titles within that organization of President and Executive Vice-President, respectively; and received consulting fees of \$8,000 each in fiscal year 1989 and \$13,000 each in fiscal years 1990 and 1991. The Executive Vice-President routinely signs filings with various state and federal agencies for PMIS as its Executive Vice-President, and he also negotiates and signs notes for the corporation.

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In addition to consulting fees, both receive additional compensation from PMSI in the form of vehicles and vehicle allowances. These costs are passed on directly to the Commonwealth through DMR contracts and indirectly through the transportation agreement between WORK and PMSI.

PMSI and WORK as related entities fall under those provisions of the regulation governing the reimbursement of related parties. The existence of this relationship was not disclosed to the regulatory agencies of the Commonwealth, in direct violation of the reporting requirements. Using cost reports filed with the Rate Setting Commission and UFRs filed with the Division of Purchased Services, we identified at least \$105,526 that the Commonwealth would have saved during the audit period had the relationship between these entities been disclosed.

In addition, the process employed by WORK in procuring transportation services from PMSI completely disregards accepted management principles used in the acquisition of goods and services, as well as standard controls designed to ensure the appropriateness of invoices submitted for payment. The manner in which the services were acquired and paid for undermines the integrity of the procurement process at WORK.

The following summarizes the practices that are contrary to accepted procurement practices:

- o A three-year agreement resulting in almost \$1 million in fees was awarded without competitive bid.
- o The agreement was verbal, not written.
- o Normal financial controls in place at WORK were not followed in the case of PMSI invoices.
- o Two members of the executive management of WORK, the entity that awarded the contract, were receiving fees from PMSI, the recipient of the contract.

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Recommendation: The Division of Purchased Services (DPS) should examine costs submitted to purchasing agencies for reimbursement and determine what additional overpayments that may have been made, including consulting fees and the use of PMSI vehicles by the President and Executive Vice-President of WORK. We also recommend that DPS work with the purchasing agencies to recover the overpayments made directly to PMSI under the DMR contract and those resulting from the agreement with WORK.

c. WORK's Acquiring Health Insurance through CP&S and Assuming CP&S's Utility Costs Resulted in an Overpayment of at Least \$327,661 by the Commonwealth: Consolidated Products and Services (CP&S) filed corporation papers with the Commonwealth's Secretary on June 11, 1981. The purpose of this not-for-profit corporation is to provide employment to handicapped individuals in a manufacturing setting, principally the production of medical supplies. The corporation employs approximately 24 handicapped individuals in the production of a number of items sold to hospitals, wholesalers, and retail buyers. In some cases CP&S produces brand name items for major companies.

Both the President and Executive Vice-President of WORK represent CP&S at a variety of events and conferences. The President's responsibilities include assessing tasks for appropriateness, resolving safety issues, and representing CP&S with NISH, a national organization that attempts to secure contracts for employment of the handicapped.

The Executive Vice-President of WORK periodically takes trips to sales conventions and other marketing activities on behalf of CP&S. The President and Executive Vice President are each paid \$15,000 per year as consultants to CP&S.

(1) Health Insurance Coverage: CP&S provides group health insurance and dental coverage to its employees, as well as the employees of WORK and PMSI,

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under its self-insurance plan. Premiums are collected from these organizations, and the health and dental claims are paid as they become due. Health insurance premiums paid to CP&S by WORK and PMSI are included in their reimbursement from the Commonwealth. Currently, employees pay a portion of the cost of this coverage through payroll deductions.

There was no initial contribution made by any of the other companies to CP&S when this insurance plan commenced. All individuals covered by the plan have identification cards describing them as employees of CP&S, and applications for coverage indicate that they are employed by that corporation. A representative of the insurance consultants to CP&S, characterized this situation as a number of companies joining together to provide less expensive insurance coverage to their employees. Although there is a separate account maintained by CP&S for the payment of claims, there are no internal or external restrictions on the corporation regarding the use of funds generated by the premiums.

Our review disclosed that since CP&S has administered this self-insurance plan, the insurance premiums have exceeded the claims, generating a surplus for CP&S. This surplus totaled \$178,661 for the four-year period ended June 30, 1991, as follows:

Fiscal Year 1988	\$112,586
Fiscal Year 1989	55,639
Fiscal Year 1990	38,992
Fiscal Year 1991	<u>(28,556)</u>
	<u>\$178,661</u>

This surplus has made a major contribution to the financial viability of CP&S. The net effect has been that state funds earmarked for the care of handicapped individuals were diverted to other uses.

None of the other companies made any contributions for the initial funding of the plan, share any of the liability, or redistribute any of the surplus.

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These circumstances demonstrate that CP&S, in addition to its manufacturing and packaging activities, is in the business of selling insurance coverage. It is not one company in a group that pools resources and risk as described by the consultant. The surplus generated by the premiums paid to CP&S represent an overpayment under the related party provisions of the 808 CMR 1.00 and should be recovered.

(2) Utilities and Common Costs: We estimate that for the four-year period ended June 30, 1991 WORK also paid approximately \$149,000 of utilities and common costs that should have been borne by CP&S. As a result, the Commonwealth has subsidized the operation of CP&S through the disproportionate allocation of costs.

During the first three years of this four-year period CP&S did not pay any utilities for the space it leased within the Arlington Street complex. In addition, it appears that CP&S did not pay any of the common costs of the property until fiscal year 1990, and then paid a disproportionately small share. The effect of having WORK pay for the utilities and the common costs of the property rented by CP&S was to create an improved financial image of CP&S for presentation to banks, potential donors, and other interested parties. For the four-year period ended June 30, 1991 we estimate that WORK paid approximately \$149,000 of utilities and common costs that should have been borne by CP&S.

This practice of generating a surplus on health insurance premiums and having WORK assume virtually all of CP&S's utility and common costs resulted in the presentation of CP&S as a healthier financial entity than it actually was during this period. It also resulted in the absorption of these costs by a corporation that was able to include them in its reimbursable costs.

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We estimate that the financial benefit derived from this arrangement at the expense of WORK and PMSI was \$327,661. Without this influx of income from insurance premiums and the exemption from those operating costs assumed by WORK, CP&S would have had an estimated negative net worth of (\$30,534) on June 30, 1991, rather than the balance of \$265,613 indicated in its financial statements.

It appears that the financial stability of CP&S has depended on the surplus premiums and the costs assumed by WORK. The favorable conditions under which CP&S operated were not disclosed to readers of their financial statements.

Recommendation: The Division of Purchased Services (DPS) should oversee purchasing agency's adjustments of the reimbursement rates for WORK and PMSI to reflect the surplus in health insurance premiums and the assumption of utility and common costs by WORK. DPS should work with the purchasing agencies to recover these funds.

Also, DPS should require a written agreement between CP&S, WORK, and PMSI outlining the responsibilities of all parties, including distribution of future surpluses.

Finally, DPS should review all cost allocations made by WORK on its UFRS until all outstanding issues have been resolved.

2. The Commonwealth Was Charged for the Salaries of the President and the Executive Vice-President of WORK, Inc., While They Were Actively Representing Other Corporations

During part of fiscal years 1987 and 1988 the President of WORK was granted a sabbatical by WORK's Board of Directors. There was no board vote on or other documented approval for this sabbatical other than the board's acknowledging his return. An examination of the cost reports filed during the period of the President's sabbatical do not reveal any disclosure of this event and report the President as a full-time employee of WORK.

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WORK should not have been reimbursed by the Commonwealth for the salary of the President during the time he spent on sabbatical. If such an expenditure of Commonwealth funds is to be made, we believe it should be justified by the provider and approved by the purchasing agency as a reasonable and appropriate expenditure of state funds before the fact and not surreptitiously by withholding the information from state officials. Over \$50,000 in salaries, fees, and benefits was paid to the President during his absence.

The Executive Vice-President of WORK periodically takes trips on behalf of CP&S. In May 1991 the Executive Vice-President represented CP&S at a conference in Europe. The attendance records at WORK indicate that the Executive Vice-President did not take any personal leave time during May 1991. In an interview on February 4, 1992, he indicated that this trip was solely for the benefit of CP&S and that it was totally independent of his responsibilities at WORK. Therefore, any such activities should not have been included in the reimbursable costs of WORK, and personal time accrued by both the President and Executive Vice-President should be charged for these and all other similar activities.

These two examples further illustrate the need for the Board of Directors of WORK to clearly define the duties and responsibilities of WORK's President and Executive Vice-President.

3. The Board of Directors, the Management, and the Accountant Failed to Disclose Related Party Transactions

In addition to the related party transactions between the corporations, there were many other related transactions between individual board members, management employees, and the individual corporations that were not disclosed. At least 12 of the 29 board members and officers of the corporations were involved in financial transactions with one or more of the

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corporations. Yet the Boards of Directors and the management of the corporations, as well as their accountant, failed to disclose the extent of related party transactions on the filings with the Rate Setting Commission (RSC), the Division of Purchased Services, the Attorney General's Office, and the Internal Revenue Service (IRS).

We reviewed the RSC cost reports and DPS UFRs for WORK and PMSI that were filed with the RSC and DPS for fiscal years 1988, 1989, 1990, and 1991. In addition, we reviewed the financial statements, IRS Forms 990, and the Attorney General's Forms PC for WORK, PMSI, CP&S, REAL, and FRIENDS. There is no disclosure of any related party transactions on any of these filings beyond a partial disclosure in 1988 and the 1991 partial disclosure made after the commencement of our audit.

In 1988 WORK disclosed three relationships on its Form RSC 1100. These individuals were board members of WORK who maintained an ongoing business relationship with WORK. Two sold insurance to WORK, and the other maintained a banking relationship with the corporation. However, these disclosures, which were never made again, represented only a small segment of WORK's related party activities.

Our audit disclosed that in addition to the related party transactions between the corporations that were not disclosed, there were many other related transactions between board members of these corporations, management employees, and the corporations that were not disclosed. For example, real estate was leased to WORK by three board members of the corporations, the board Presidents of CP&S and PMSI contracted for services provided by WORK and CP&S, and an attorney board member of WORK performed legal services for REAL and had been a trustee of the real estate trust that leased property to WORK.

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Of those 29 who were board members and officers of the corporations during fiscal year 1991, we identified 12 (41%) who were involved with financial transactions that should have been disclosed as related party transactions (see Exhibit IV).

The filings with the Attorney General's Public Charities Division and the IRS Form 990 both specifically ask about related party transactions. These documents were prepared by the accounting firm used by all five corporations. A partner in the firm was the Treasurer of REAL and an advisory member of WORK's board. Another partner of the firm was the clerk of CP&S. None of these relationships (except for the three disclosed in 1988) were disclosed on any of the filings or in the financial statements prior to the commencement of the audit.

In addition to the accountant who was an advisory member to the WORK board, there was at least one attorney on its board who should have recognized the related nature of these transactions. The 1988 disclosure proves that management understood the concept of related party and their responsibility to report such activities. It was not until the corporations changed accounting firms for fiscal year 1991 that any other related activity was disclosed. Yet even these disclosures were limited to transactions between the not-for-profit corporations and did not include employees of WORK or transactions with directors.

During the audit we asked if anyone had ever given WORK a ruling stating that these transactions were not related in nature. We were informed that three independent reviews had been conducted the RSC, by the Executive Office of Health and Human Services (EOHHS) auditors, and by WORK's attorneys. However, when we asked for any opinion, ruling, or correspondence from these parties regarding the related party matters, we were told that none existed.

Based on the evidence, at least some of these transactions were recognized by the board to be related; with this knowledge they intentionally failed to disclose these transactions on tax returns, cost reports, and filings with the Public Charities Division of the Attorney General's Office; and their accountant withheld this information from users of the financial statements.

4. WORK Misled the Commonwealth about Charging the Cost of Certain Vehicles to State Contracts and Charged Twice for a Portion of One Vehicle's Cost

WORK's President and Executive Vice-President both had the use of vehicles whose costs had been charged to WORK's contracts. During fiscal year 1987 DMR informed WORK that DMR was no longer going to reimburse WORK for certain vehicles, specifically a 1984 BMW and a 1987 Lincoln Continental. Management of WORK informed DMR that the cost of these vehicles would no longer be included on its cost report. Based on this conversation, DMR was led to believe that it would no longer be charged for the vehicles.

In June 1988 these vehicles were sold to PMSI. The President and Executive Vice-President have continued to use these vehicles or replacement vehicles and to receive vehicle allowances through fiscal years 1989, 1990, and 1991, and into fiscal year 1992.

PMSI included the cost of vehicles and vehicle allowances on its cost report and UFR during the entire audit period. All of PMSI's costs during the period were charged either directly to DMR and its contract or to WORK for the services provided to it. Included in these costs and allocations were the vehicle expenses relative to the President's use of a BMW and the Executive Vice-President's use of a vehicle or his receipt of an allowance. Although DMR was led to believe that it would no longer be charged for these vehicles, the costs continued to be incurred by the Commonwealth. Furthermore, the BMW had been fully depreciated (a reimbursable cost) while it was owned by WORK.

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The Commonwealth continued to pay for this fully depreciated asset when it was sold to PMSI, resulting in the Commonwealth paying for a portion of the BMW a second time.

Shortly after the vehicles were acquired by PMSI, a new BMW was purchased for \$43,000. The transaction was financed by trading in the old BMW for \$15,000 and by PMSI's providing an additional \$20,000 as a car allowance for the President and an additional \$8,000 as a loan for President. He then paid the corporation back through an \$8,000 non-interest-bearing note. The monthly payments on this obligation were made through monthly deductions from his consulting fees. PMSI carries the vehicle on its books at full cost, including the President's share.

The President has characterized his monthly payment as a user fee rather than a loan. He stated that the vehicle is the property of PMSI and that he had no equity interest in it. However, as noted above, when the new BMW was purchased by PMSI in 1988 a portion of the cost was offset by the trade-in of the 1984 BMW previously used by the President. In determining the amount to be paid by the President, WORK used his equity in the vehicle to reduce his payments on the new one. There would be no need for an equity calculation if the President were merely paying a user fee.

The Executive Vice-President ceased to use a vehicle owned by either WORK or PMSI. He currently receives a monthly allowance of \$650 from PMSI for vehicle expenses related to his personal vehicle, which was registered in New Hampshire during the time of the audit. At the time he returned the 1987 Lincoln to PMSI, his equity in the vehicle was calculated and he was compensated for that interest.

Recommendation: The Division of Purchased Services (DPS) should determine an appropriate car allowance under existing related party provisions of the

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regulations and recover all money paid in excess of that amount. DPS should work with the purchasing agencies to recover these overpayments.

CONCLUSION

WORK and its related corporations have created an environment in which related party transactions are a routine and accepted way to conduct business with the Commonwealth. The Boards of Directors of the corporations have members who either do business with one of the corporations, are directors of more than one of the corporations, or are incorporators of a related corporation.

Both the President and Executive Vice-President of WORK receive a large salary from WORK plus consulting fees from three of the related corporations. Total compensation from these sources amounted to \$115,500 and \$114,029, respectively, in fiscal year 1991. Both have significant levels of authority within WORK and the other corporations. The result of the Boards of Directors' vesting such authority in these individuals defeated the internal controls the corporation had in place below the executive level. This authority allowed these individuals and corporations to set cost allocations and to establish the cost levels of inter-company transactions such as health insurance, transportation, and improvements made to property owned by REAL. It ultimately resulted in the diversion of state funds intended for clients to non-client uses.

Improvements Needed in the Reimbursement System

Many of the conditions and problems discussed throughout this report could have been prevented or detected by the Commonwealth had the cost reporting system required (1) more specific cost information from the vendors, (2) the Board of Directors to individually make related party disclosures within the body of the cost report, (3) an audit of selected providers, and (4) the cost

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reports to be used to reconcile the actual expenditures with the contracted amounts. Recent improvements to the disclosure and cost reporting systems, as are currently being implemented by the Division of Purchased Services, should help to address these key points. By incorporating the following suggestions, DPS can reform and improve the current system and reduce the likelihood of the recurrence and loss to the Commonwealth.

a. The reporting system should be reformed to include more specific information: In fiscal year 1990 DPS assumed the rate-setting function for human services from the Rate Setting Commission. (The Commission had filled this role since the early 1970s.) When rates of reimbursement were approved by the commission, a number of different cost-reporting documents were used, the latest being the RSC 1100. This report was an unaudited information-gathering tool that required an analysis of certain costs, as well as a breakdown of organizational cost by program. This information was never forwarded or provided to purchasing agencies that were responsible for establishing the rates of payment in negotiated contracts. It also required that the provider identify related party transactions in a number of different categories, including real estate, vehicles, and debt.

The Division of Purchased Services brought a change in reimbursement philosophy: the system shifted from being strictly unit rate-based to measuring reasonableness of cost based on industry norms. It was hoped that this would address some of the problems that had developed within the rate-setting methodology, including stability within the rate structure and timeliness in rate promulgation.

The current report, the UFR (Uniform Financial Report), supersedes the RSC 1100 and combines a number of cost areas into single line items, which are then measured against an approved component price range. If the vendor falls

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within the component boundries, the cost is assumed to be reasonable for contract negotiation purposes. From the current report there is no way for DPS to ascertain some of the items that make up some component costs. For example, occupancy costs include rent, property insurance, utilities, repairs, and a number of other items. Under the former system total occupancy costs would be detailed in a subsidiary schedule, but under the current system just the gross occupancy cost is included. It is possible that DPS can not determine whether the occupancy costs are composed of reasonable or unreasonable costs or whether there is a potentially unnecessary, abusive or questionable transaction included in these costs; if the independent accountant departs from Generally Accepted Government Auditing Standards and their working papers have not been selected for quality assurance review. At the same time as this new pricing method is being implemented, the Division continues to refine and expand its uniform financial reporting mechanism. Although, we acknowledge that the DPS UFR document is a distinct improvement over its predecessor, RSC 1100 in many ways; we believe that DPS should consider the inclusion of additional schedules that require the provider to detail transactions in the areas most susceptible to abuse, such as real estate, vehicles, and program debt. The inclusion of this information within the report will do nothing to impair the current process, but will supply information that enhances the accountability of the system.

b. The reimbursement system should provide timely and effective cost verification: When providers contract with a state agency to provide services, the contract becomes the mechanism for payment. It is also the basis of the rate of reimbursement, as the vendor discloses the projected contract cost to the agency and it is either approved, disapproved, or

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amended. Once the contract is approved, the system is capable of generating payments to the provider for services rendered. The ability to compare actual costs incurred to costs projected may not be present for some time unless the state purchasing agencies improve program and financial monitoring during the contract year. For example, an agency with a contract starting on July 1, 1992 will not have to file a cost report including that contract until November 15, 1993. In our view, this delay in the ability of purchasing and oversight agencies to make a precise analysis of costs projected to costs incurred during the contracted year may place Commonwealth funds at risk, unless adequate monitoring activities exist, particularly in cases in which related party transactions may exist and may not have been disclosed.

Every system will have blind spots and weak points; however, it is necessary to be aware of them and take steps to mitigate their impact. The inclusion of subsidiary information and the required disclosure of any relationships and the formal denial, under penalties, of any relationships within the body of the report provide at least a minimum level of protection. Routine examination of this information, combined with both random and selected audits, would promote proper disclosure. Earlier comparison of projected and actual costs, by means of regular monitoring efforts, offers the opportunity to identify potential abuse before it becomes buried in the resulting inflated program cost base. Properly designed and implemented, this protection can be added without disruption and without additional expenditures by vendors for professional fees.

c. More precise definitions and guidelines are needed for related party transactions and relationships: The instructions issued by DPS for the completion of the uniform financial report require related party transactions

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to be disclosed. The regulation is explicit in its description of related party.

Under the existing regulations and instructions and the standards of the accounting profession, the independent auditor has been required to report on nondisclosure of related party transactions. Many of the problems discussed in this report could have been prevented or detected if each member of the Board of Directors had been required to disclose any related party transactions or affirm in writing that none existed. The current system relies on the public accountant to identify and disclose such transactions. The responsibility for disclosing potentially abusive relationships should include the Board of Directors as well as the accountant. Current steps taken by DPS to require Board Certification as to related party transactions and to include numerous levels of required disclosure, starting during the proposal submission process, should help mitigate this problem. Additionally, new DPS guidelines, which fully define the terms of ownership, control, and affiliation as they pertain to related party transactions and which include examples and worksheets assisting providers in determining whether and to what extent the related party regulations may apply, should go much further than prior systems in helping providers to ascertain the full range of their disclosure and cost limitation requirements when they choose to do business with related parties.

d. A process is needed for recovering overpayments: DPS should have a recovery mechanism for collecting overpayments. Currently, there are administrative procedures that can be employed in such situations; however, these procedures may force purchasing agencies to choose between continuity of care and the recovery of funds. When the lack of proper safeguards results in overpayments, recovery is hampered by difficulties in finding appropriate

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placements for the clients, forcing the continued funding of programs that are overpaid. It is extremely difficult both to recover those funds and to maintain the level of care provided to clients from the same proceeds. The taxpayers and Commonwealth should not be in this position. DPS has implemented an audit resolution policy and a not-for-profit provider surplus revenue provision through its regulations to recover overpayments.

DPS must take the necessary steps to coordinate the recovery of the overpayments made to WORK and PMSI as a result of the related party transactions between the four corporations and of other questionable activities. DPS and the purchasing agencies must also evaluate WORK's and PMSI's status as vendors. Until and unless there is a reconfiguration of these organizations and the related entities, the Commonwealth will be unable to accept cost and budget information as presented. Another result of this audit was the determination that these organizations have no financial credibility. Cost reports, tax filings, and other documents reflect what management of WORK chose to report, with the implied approval of the Boards of Directors. The Commonwealth has no obligation to continue in a relationship that has proven to be abusive and should consider debarment proceedings.

In our opinion, DPS is implementing a cost reporting and reimbursement system that is timely, effective, and fair while increasing the level of protection against potentially abusive transactions and unnecessary and unreasonable costs. We believe that several regulatory and policy changes are needed to bring the level of assurance offered by the reimbursement system to an appropriate level. These steps can be taken without changing the reimbursement philosophy, reducing vendor incentive, or without placing one client or program at risk. Failure to implement proper controls only serves to perpetuate an abusive and uncontrollable system that can be manipulated by

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a vendor, result in massive overpayments, and destroy the credibility of a provider community that is predominately honest.

Recommendation: DPS should develop and implement:

1. A reporting system that requires certain types of more specific cost information and offers the ability to capture some of the abuses that exist, particularly as they relate to related party transactions. Although the numerous levels of disclosure currently required by DPS do provide some protection, we recommend that additional cost information should be gathered to expand on existing DPS protections.
2. A compliance monitoring system, perhaps modeled after the Internal Revenue Service's practice of utilizing both random and selected requests by DPS for audits, by the Office of the State Auditor to examine questionable providers annually. In addition, DPS's Bureau of Audit should conduct follow-up audits and randomly selected audits of providers in accordance with its legislative mandate. The possibility of an in-depth provider compliance audit will do more to ensure regulatory compliance than impractical penalties included in the regulation should the need be determined.
3. A modified system for Related Party certification which includes language that attests to the specific fact that all Related Party disclosures have been made in the UFR. Such a document must include Board certification under pains and penalties of perjury.

We also recommend that purchasing agencies and DPS:

1. Pending the restructuring of the corporations, require a board member of PMSI, rather than a "consultant," to sign the cost report and accept responsibility for its content.
2. Require a plan from WORK and PMSI for paying back those costs found to be excessive, unreasonable, and non-reimbursable. This plan should take into consideration continuity of care and the resources of CP&S and REAL. The time frame of this plan should not exceed the time it took for WORK and PMSI to generate these overpayments (approximately four years).
3. Review the compensation paid to the President and Executive Vice-President for reasonableness and appropriateness for the industry. This limit should take into account all benefits such as vehicles, annuities, life insurance, as well as any compensation received from other related corporations.
4. Require the Board of Directors of WORK to clearly define the duties and responsibilities of its President and Executive Vice-President and to document its approval for all transactions between these individuals and the corporation. They should not, for example, be allowed to change or approve each other's expenses or salary levels and to charge personal expenses to the corporation. The President

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should be required to maintain an attendance record as all other employees do.

5. Require the Boards of Directors of the corporations to accept responsibility for filing official documents, cost reports, and tax returns and, for the content of such documents, to vote independently regarding the appointment of a public accountant and their own counsel.
6. Determine whether the sabbatical taken by the President of WORK was a reimbursable expense to the Commonwealth and, if not, take action to recover the overpayment.
7. Consider debarment proceedings for failure to comply and remedy the abuses noted within this report.

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EXHIBIT I

Flow of Funds from WORK to Related Entities

	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>Total</u>
WORK to PMSI	-	\$287,925	\$310,803	\$342,186	\$ 940,914
WORK to REAL	\$119,220	\$217,953	\$283,020	\$339,000	959,193
WORK to CP&S*	\$356,766	\$362,941	\$437,388	\$474,852	<u>1,631,947</u>
TOTAL					<u>\$3,532,054</u>

* Includes CP&S and PMSI premiums

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EXHIBIT II

Property Rented by REAL to WORK and Its Affiliated Companies
and the Fiscal Year 1992 Annual Rent

Quincy		
Arlington St. Complex	(WORK)	\$119,580
	(CP&S)	35,000
	(PMSI)	15,000
8-10 Rockview St.		43,200
587 Hancock St.		40,800
74 Greenleaf St.		11,100
129 Winthrop St.		11,520
Cove Way Condominium		24,000
Braintree		
273 Franklin St.		28,400
233 River St.		13,680
Randolph		
20 Prospect St.		28,800
Brighton		
114 North Beacon St.		90,000
Methuen		
2 East Capitol St.		<u>36,000</u>
		<u>\$497,080</u>

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EXHIBIT III

Excessive Revenues by Site by Year (Summary)

<u>Site</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>	<u>Total</u>
Arlington St.	\$46,282	\$101,132	\$103,188	\$120,450	\$371,052
8-10 Rockview St.	-	7,061	13,125	12,807	32,993
74 Greenleaf St.	10,120	10,210	10,210	10,210	40,750
587 Hancock St.	-	16,194	17,194	18,502	51,890
20 Prospect St.	-	636	14,584	13,260	28,480
273 Franklin St.	-	14,308	12,608	11,138	38,054
Cove Way	-	-	4,543	9,322	13,865
129 Winthrop St.	<u>9,857</u>	<u>10,011</u>	<u>10,011</u>	<u>10,011</u>	<u>39,890</u>
TOTAL	<u>\$66,259</u>	<u>\$159,552</u>	<u>\$185,463</u>	<u>\$205,700</u>	<u>\$616,974</u>

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EXHIBIT III-1

Excessive Revenues by Year - Arlington St. Complex1988

Rent Paid by WORK	\$ 69,600
Rent Paid by PMSI	12,000
Rent Paid by CP&S	<u>15,000</u>
Total Rent Paid by Related Corporations	\$ 96,600

Allowable Costs	
Interest	\$ 21,379
Depreciation	
Parcel 1	5,491
Parcel 2	2,383
Parcel 3	6,029
Depreciation Leasehold Improvements	<u>15,036</u>
Total Allowable Cost	\$ 50,318

Excessive Revenues 1988	<u>\$ 46,282</u>
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1989

Rent Paid by WORK	\$ 69,600
Rent Paid by PMSI	15,000
Rent Paid by CP&S	15,000
Second Lease to WORK	<u>49,980</u>
Total Rent Paid by Related Corporations	\$149,580

Allowable Costs	
Interest	\$ 19,509
Depreciation	
Parcel 1	5,491
Parcel 2	2,383
Parcel 3	6,029

Depreciation Leasehold Improvements	<u>15,036</u>
Total Allowable Cost	\$ 48,448

Excessive Revenues 1989	<u>\$101,132</u>
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EXHIBIT III-1 (Continued)

Excessive Revenues by Year - Arlington St. Complex1990

Rent Paid by WORK	\$ 69,600
Rent Paid by PMSI	15,000
Rent Paid by CP&S	15,000
Second Lease to WORK	<u>49,980</u>
Total Rent Paid by Related Corporations	\$149,580

Allowable costs	
Interest	\$ 17,453
Depreciation	
Parcel 1	5,491
Parcel 2	2,383
Parcel 3	6,029
Depreciation Leasehold Improvements	<u>15,036</u>
Total Allowable Cost	\$ 46,392

Excessive Revenues 1990	<u>\$103,188</u>
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1991

Rent Paid by WORK	\$119,580
Rent Paid by PMSI	15,000
Rent Paid by CP&S	30,000
Second Lease to WORK	<u>-</u>
Total Rent Paid by Related Corporations	\$164,580

Allowable Costs	
Interest	\$ 15,191
Depreciation	
Parcel 1	5,491
Parcel 2	2,383
Parcel 3	6,029
Depreciation Leasehold Improvements	<u>15,036</u>
Total Allowable Cost	\$ 44,130

Excessive Revenues 1991	<u>\$120,450</u>
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Total Excessive Revenues 1988-1991	<u>\$371,052</u>
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EXHIBIT III-2

Excessive Revenues by Year - 8-10 Rockview St.1989

Rent Paid by WORK	\$32,400
Allowable Costs	
Interest	17,775
Depreciation	<u>7,564</u>
Total Allowable Cost	\$25,339
Excessive Revenues 1989	<u>\$ 7,061</u>

1990

Rent Paid by WORK	\$42,800
Allowable Costs	
Interest	20,170
Second Mortgage	1,941
Depreciation	<u>7,564</u>
Total Allowable Cost	\$29,675
Excessive Revenues 1990	<u>\$13,125</u>

1991

Rent Paid by WORK	\$42,800
Allowable Costs	
Interest	18,752
Second Mortgage	3,677
Depreciation	<u>7,564</u>
Total Allowable Cost	\$29,993
Excessive Revenues 1991	<u>\$12,807</u>
Total Excessive Revenues 1988-1991	<u>\$32,993</u>

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EXHIBIT III-3

Excessive Revenues by Year - 74 Greenleaf St.1988

Rent Paid by WORK	\$11,100
Allowable Costs	
Interest	90
Depreciation	<u>890</u>
Total Allowable Cost	\$ 980

Excessive Revenues 1988	<u>\$10,120</u>
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1989

Rent Paid by WORK	\$11,100
Allowable Costs	
Interest	-
Depreciation	<u>890</u>
Total Allowable Cost	\$ 890

Excessive Revenues 1990	<u>\$10,210</u>
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1990

Rent Paid by WORK	\$11,100
Allowable Costs	
Interest	-
Depreciation	<u>890</u>
Total Allowable Cost	\$ 890

Excessive Revenues 1990	<u>\$10,210</u>
-------------------------	-----------------

1991

Rent Paid by WORK	\$11,100
Allowable Costs	
Interest	-
Depreciation	<u>890</u>
Total Allowable Cost	\$ 890

Excessive Revenues 1991	<u>\$10,210</u>
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Total Excessive Revenues 1988-1991	<u>\$40,750</u>
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EXHIBIT III-4

Excessive Revenues by Year - 587 Hancock St.1989

Rent Paid by WORK	\$39,600
Allowable Costs	
Interest	16,424
Depreciation	<u>6,982</u>
Total Allowable Cost	\$23,406
Excessive Revenues 1989	<u>\$16,194</u>

1990

Rent Paid by WORK	\$42,800
Allowable Costs	
Interest	18,624
Depreciation	<u>6,982</u>
Total Allowable Cost	\$25,606
Excessive Revenues 1990	<u>\$17,194</u>

1991

Rent Paid by WORK	\$42,800
Allowable Costs	
Interest	17,316
Depreciation	<u>6,982</u>
Total Allowable Cost	\$24,298
Excessive Revenues 1991	<u>\$18,502</u>
Total Excessive Revenues 1988-1991	<u>\$51,890</u>

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EXHIBIT III-5

Excessive Revenues by Year - 20 Prospect St.1989

Rent Paid by WORK	\$ 4,800
Allowable Costs	
Interest	-
Depreciation	<u>4,164</u>
Total Allowable Cost	\$ 4,164
Excessive Revenues 1989	<u>\$ 636</u>

1990

Rent Paid by WORK	\$28,800
Allowable Costs	
Interest	10,052
Depreciation	<u>4,164</u>
Total Allowable Cost	\$14,216
Excessive Revenues 1990	<u>\$14,584</u>

1991

Rent Paid by WORK	\$28,800
Allowable Costs	
Interest	11,376
Depreciation	<u>4,164</u>
Total Allowable Cost	\$15,540
Excessive Revenues 1991	<u>\$13,260</u>
Total Excessive Revenues 1989-1991	<u>\$28,480</u>

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EXHIBIT III-6

Excessive Revenues by Year - 273 Franklin St.1989

Rent Paid by WORK	\$18,933
Allowable Costs	
Interest	-
Depreciation	<u>4,625</u>
Total Allowable Cost	\$ 4,625
Excessive Revenues 1989	<u>\$14,308</u>

1990

Rent Paid by WORK	\$28,400
Allowable Costs	
Interest	11,167
Depreciation	<u>4,625</u>
Total Allowable Cost	\$15,792
Excessive Revenues 1990	<u>\$12,608</u>

1991

Rent Paid by WORK	\$28,400
Allowable Costs	
Interest	12,637
Depreciation	<u>4,625</u>
Total Allowable Cost	\$17,262
Excessive Revenues 1991	<u>\$11,138</u>
Total Excessive Revenues 1989-1991	<u>\$38,054</u>

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EXHIBIT III-7

Excessive Revenues by Year - Cove Way1990

Rent Paid by WORK	\$18,000
Allowable Costs	
Interest	9,328
Depreciation	<u>4,129</u>
Total Allowable Cost	\$13,457
Excessive Revenues 1990	<u>\$ 4,543</u>

1991

Rent Paid by WORK	\$24,000
Allowable Costs	
Interest	10,549
Depreciation	<u>4,129</u>
Total Allowable Cost	\$14,678
Excessive Revenues 1991	<u>\$ 9,322</u>
Total Excessive Revenues 1990-1991	<u>\$13,865</u>

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EXHIBIT III-8

Excessive Revenues by Year - 129 Winthrop St.1988

Rent Paid by WORK	\$11,520
Allowable Costs	
Interest	154
Depreciation	<u>1,509</u>
Total Allowable Cost	\$ 1,663
Excessive Revenues 1988	<u>\$ 9,857</u>

1989

Rent Paid by WORK	\$11,520
Allowable Costs	
Interest	-
Depreciation	<u>1,509</u>
Total Allowable Cost	\$ 1,509
Excessive Revenues 1989	<u>\$10,011</u>

1990

Rent Paid by WORK	\$11,520
Allowable Costs	
Interest	-
Depreciation	<u>1,509</u>
Total Allowable Cost	<u>\$ 1,509</u>
Excessive Revenues 1990	<u>\$10,011</u>

1991

Rent	
Paid by WORK	\$11,520
Allowable Costs	
Interest	-
Depreciation	<u>1,509</u>
Total Allowable Cost	\$ 1,509
Excessive Revenues 1991	<u>\$10,011</u>
Total Excessive Revenues 1988-1991	<u>\$39,890</u>

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EXHIBIT IV

Fiscal Year 1991 Directors, Officers, and Executives
Having Financial Transactions with One or More of the Related Corporations

<u>Corporation and Title</u>	<u>Financial Transaction</u>
WORK	
Director	Insurance
Director	Banking
Director	Attorney
Director	Reciprocal Donations
CPA	Auditing
REAL	
CPA	Auditing
Director	Board Member CP&S
CP&S	
Director	Purchases Services
CPA	Auditing
PMSI	
Director	Purchases Services
Director	Real Estate
Director	Banking
ALL CORPORATIONS	
President	Various
Executive Vice-President	Various



A. JOSEPH DeNUCCI
2 11 36

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

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FOR IMMEDIATE RELEASE
February 18, 1993

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DeNUCCI SAYS TWO VENDORS BILKED STATE OF \$1 MILLION OVER FIVE YEARS

State Auditor A. Joseph DeNucci reported today that two vendors under contract to the Department of Mental Retardation overcharged the Commonwealth \$1 million dollars over a five-year period.

DeNucci's audit disclosed that the two providers -- Southeastern Regional Vendor Educational and Support Services, Inc. (SERVESS) and Day and Residential Services Options, Inc. (DARSO) -- intentionally inflated and concealed costs included in state reimbursements by hiding relationships with companies or realty trusts they owned or controlled. The providers' contracts were for operating and equipping various day program and residential facilities for de-institutionalized Department of Mental Retardation clients.

"This audit proves how vulnerable the Commonwealth's purchase-of-service system is to fraud, waste, and abuse," stated Auditor DeNucci. "The state's primary assurance of compliance cannot be from the providers. SERVESS and DARSO bilked the state for five years, hurting both the taxpayers and the mentally retarded clients they were supposed to be serving."

DeNucci has referred his findings to the appropriate law enforcement and oversight agencies.

According to the audit, companies established by SERVESS and DARSO to inflate prices and defraud the state were Community Services, Inc. (CSI), a for-profit corporation incorporated by the two individuals who founded SERVESS and DARSO and that provided consulting, accounting, and computer services for 10% of SERVESS and DARSO's operating expenses; Trescott Corporation, a for-profit company that managed the five realty trusts and was the intermediary that received the rental payments from SERVESS and DARSO; Underwood Company and TALL Enterprises, both for-profit corporations that sold and leased furniture to the providers; and five realty trusts that owned facilities leased to the providers.

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DeNucci/SERVESS & DARSO/2-2-2

"The founders of SERVESS and DARSO hid their relationship with all of these related companies," explained DeNucci, noting that state regulations require disclosure of all business dealings and transactions with related entities. "The two providers made no disclosure of any related-party transactions between their non-profit organizations and the for-profit corporations they created and controlled. This deception enabled the providers to perpetrate their scheme and exploit the Commonwealth's purchase-of-service system."

DeNucci's audit determined that SERVESS and DARSO inflated and concealed costs for management services, real estate rental, and furniture procurement. For example, CSI's invoices to SERVESS for management services were marked up and reimbursement by the Commonwealth was inflated by a total of \$450,000 over the five-year period.

Furthermore, SERVESS and DARSO bought or leased homes through the five real estate trusts they established and then leased them at a profit while hiding their ownership from the state. One property in Attleboro was leased from the actual owners by the Trescott Corporation for \$850 per month. Trescott then sub-leased the property to SERVESS for \$1,450 per month. Also, most of the properties were purchased in the mid-1980s when real estate prices had risen and a number of the trusts' mortgages were rewritten. The proceeds from the various refinancing operations were used by the vendors, through the trusts, as down payments on more properties, including a condominium in Florida.

The audit also found that the providers set up two companies, Underwood and TALL Enterprises, to buy furniture and then inflate the price before the items were resold to SERVESS and DARSO. During the audit, Underwood's invoices to the providers were inflated by almost \$200,000, more than double Underwood's purchase price.

DeNucci noted that the state's purchase-of-service system has been revised within the past year and is now based on "reasonableness" rather than on costs alone. The Division of Purchased Services has taken over the rate-setting function for human services purchased by the state. It determines "reasonableness" by comparing a provider's costs to industry norms.

"However, the system still relies heavily on provider assertions that reported costs are the result of arm's-length transactions," stated DeNucci. "As a result, providers could still conceal related-party transactions.

"With the state's annual expenditures through the purchase-of-service system having soared to more than \$2 billion, and promising to go even higher as privatization increases costs, it is essential that provider billing practices be more closely monitored and controlled," concluded Auditor DeNucci.

-more-

DeNucci/SERVESS & DARSO/3-3-3

Subsequent to the completion of the audit, the trustee of the five realty trusts pled guilty to one count of racketeering. Also, the two founders of SERVESS and DARSO each pled guilty to 14 counts of mail fraud stemming from their roles in 14 separate schemes to defraud the state of more than \$500,000. Each mail fraud charge includes a payment of restitution penalty. In addition, a civil complaint against the founders of SERVESS and DARSO resulted in their being ordered to make lease payments into an escrow account. To date, the account has a balance in excess of \$100,000, which will be turned over to the Commonwealth.



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NO. 88-6009-9

STATE AUDITOR'S
REPORT ON CERTAIN ACTIVITIES OF
SERVESS AND DARSO
(SOUTHEASTERN REGIONAL VENDOR EDUCATIONAL AND SUPPORT SERVICES, INC.)
(DAY AND RESIDENTIAL SERVICE OPTIONS, INC.)

OFFICIAL AUDIT REPORT

FEB 18 1993

ISSUED BY THE
Department of the State Auditor

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INTRODUCTION

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On November 24, 1987, at the request of the Department of Mental Retardation's (DMR) Region V Service Bureau Director, the Office of the State Auditor (OSA) initiated an audit of two human service providers, Southeastern Regional Vendor Educational and Support Services, Inc. (SERVESS) and Day and Residential Service Options, Inc. (DARSO), that contract with DMR to provide services to mentally retarded clients. The request was prompted by allegations of an excessive purchase of furniture for \$20,000 and questionable fees paid to the providers' management company, Community Services, Inc. (CSI).

Initially, we focused on these allegations; however, as we detected related parties, we expanded our audit to determine whether questionable transactions between SERVESS and DARSO caused excessive, unnecessary, and wasteful reimbursements from the Commonwealth of Massachusetts.

Based upon evidence developed by the OSA and U.S. Postal Service Inspectors and presented to a federal grand jury by the United States Attorney, indictments were returned against the two founders of SERVESS and DARSO and a trustee of five realty trusts. Indictments alleging mail fraud, racketeering, and aiding and abetting were returned against the two founders; five realty trusts that purchased and leased property to SERVESS and DARSO; the trustee of the five trusts; a furniture company; and two management companies controlled by the three individuals. The indictments allege, among other things, the manipulation of SERVESS and DARSO by the three individuals in a series of related schemes and artifices to defraud. According to the indictments, the three individuals, in executing the various schemes to defraud,

- A. Set up a management company, CSI, to manage SERVESS, ostensibly as part of an arm's-length transaction;
- B. Bought or leased homes through five different real estate trusts and then leased the homes at a profit to SERVESS and DARSO, hiding their ownership from the state; and
- C. Set up a furniture company, Underwood, and a second company, TALL Enterprises (TALL), to buy furniture at wholesale and then pass the furniture through one or both of these corporations, inflating the price at each step before selling the furniture to SERVESS and DARSO.

We are referring this report to the Internal Revenue Service, the State Department of Revenue, Division of Purchased Services, DMR, and the Attorney General for their review.

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AUDIT RESULTS	5
<u>The Founders of SERVESS and DARSO Defrauded the Commonwealth of \$1 Million over a Five-Year Period through a Scheme that Exploited the State's Purchase-of-Service System:</u> The founders of SERVESS and DARSO conspired to conceal non-arm's-length, related-party transactions by using intermediary companies or realty trusts that they owned and controlled to artificially inflate the costs reimbursed by the Commonwealth. Their scheme involved SERVESS, DARSO, CSI, Trescott (the company organized to manage the trusts' leases), Underwood, TALL, the five realty trusts, and other entities owned or controlled by the founders and a trustee of the realty trusts. The two founders were able to illegally pass on approximately \$1 million in inflated costs to the Commonwealth over a five-year period. Because they made related-party transactions, the three were required to disclose them and the actual procurement cost to both DMR and the Rate Setting Commission (RSC). Contracting forms filed by SERVESS and DARSO with the State Comptroller show no disclosure of any non-arm's-length, related-party transactions. SERVESS and DARSO, at the direction or under the control of their founders, denied any transactions with related entities, thereby hiding the partnerships.	
CONCLUSION	10
The results of this audit demonstrate that the Commonwealth's purchase-of-service system during the audit period 1985 to 1989 was vulnerable to fraud, waste and abuse. The system was vulnerable because it had no effective independent means of verifying that service providers were in fact dealing at arm's length with their suppliers. During this period, the Executive Office of Health and Human Services reported that it conducted 400 audits of the over 1,400 providers. This level of independent oversight was not sufficient to prevent abuse of the purchase-of-service system. The Commonwealth's primary assurance of providers' compliance came from the providers themselves. The principals of the SERVESS and DARSO scheme were able to defeat the system by simply not declaring that they were dealing with related parties.	
SUBSEQUENT EVENTS	13
On April 30, 1992, the trustee of the five realty trusts pled guilty to one count of racketeering.	
The two founders of SERVESS and DARSO each pled guilty to 14 counts of mail fraud stemming from their roles in 14 separate schemes to defraud the Commonwealth of Massachusetts of more than \$500,000. Each mail fraud charge includes a penalty of payment of restitution. Sentencing for both is scheduled for March 1993.	

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On December 1, 1992 the former acting Area Director for the Department of Mental Retardation's Attleboro Office was indicted on five counts of bribery in violation of United States Code section 666. The bribe was received in conjunction with the award of a 1986 day habilitation program to DARSO. The former acting Area Director had responsibilities relevant to the award of DMR contracts within the Attleboro area for the provision of day habilitation services to the mentally retarded. The indictment alleged that during the bidding process the former acting Area Director sought from DARSO (one of the three bidders) employment for his wife in the day habilitation program. The founders of DARSO agreed and following the award of the contract to DARSO, that company employed the former acting Area Director's wife in the day habilitation program and in two other programs run by DARSO.

On December 9, 1992 DARSO filed a voluntary petition with the United States Bankruptcy Court for protection from debtors under Chapter 11 of the Bankruptcy Code. DARSO listed total liabilities of \$939,303 and total assets of \$531,383 as of September 30, 1992. This is the second Chapter 11 bankruptcy filing by DARSO in Massachusetts within the last six years.

After learning of the December 9, 1992 filing, we requested and received from DARSO copies of fiscal year 1992 financial statements and minutes of the March 5, 1992 and June 24, 1992 board meetings which state in part:

**Board of Directors Meeting Minutes:
March 5, 1992**

13. Golf Course

"Mr., (the current executive director), announced that he has taken out a golf course membership on behalf of the agency at an initial cost of \$872 and annual cost of \$372. Mr. mentioned that this is for PR purposes and that board members are invited to use this membership."

16. Contract Negotiations

- e. "Mr. can borrow against accrued vacation time to the limit, in dollars, of said actual obligation. Borrowing must be repaid in monthly installments and by contract of not more than two years."

**Executive Board Meeting
June 24, 1992**

6. "Mr. asked that the minutes of the last meeting of the board be amended, when referring to Mr. (the current executive director's) loan to read, refer only to accumulated vacation time, not vacation and sick time."

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On April 3, 1992 the Executive Director was advanced approximately \$12,000 for accrued sick days. The June 24, 1992 executive board meeting amended the April 3 minutes to designate the advance as accumulated vacation time and not sick time.

Prior to this filing, the Department of Mental Retardation had notified DARSO that the Commonwealth of Massachusetts would be terminating all existing contracts on December 31, 1992.

Attached to the November 1990 indictment of the SERVESS and DARSO founders was a civil complaint against the founders, their business partner, the Trescott Corporation, and the five realty trusts pursuant to 18 U.S.C. section 1345. The result of the civil complaint was an injunction directing the non-profits, SERVESS, and DARSO to make lease payments into an escrow account. The fiduciary of the account, an Assistant United States Attorney, was responsible for making Trescott's mortgage payments. To date the account has a balance in excess of \$100,000, which will be turned over to the Commonwealth.

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INTRODUCTION

Background

On November 24, 1987, at the request of the Department of Mental Retardation's (DMR) Region V Service Bureau Director, the Office of the State Auditor (OSA) initiated an audit of two human service providers, Southeastern Regional Vendor Educational and Support Services, Inc. (SERVESS) and Day and Residential Service Options, Inc. (DARSO), that contract with DMR to provide services to mentally retarded clients. The request was prompted by allegations of an excessive purchase of furniture for \$20,000 and questionable fees paid to the providers' management company, Community Services, Inc. (CSI).

SERVESS and DARSO are both non-profit corporations organized under Chapter 180 of the Massachusetts General Laws as charitable organizations to equip and operate day program centers, community-based residential centers, and temporary shelter facilities as defined by the General Laws. SERVESS and DARSO both contract with the state to provide these services to de-institutionalized mentally retarded wards of the state.

Pursuant to a consent decree in 1975, the Commonwealth of Massachusetts agreed to move mentally retarded individuals from state institutions into residential settings in the community. As the agency responsible for transferring these clients from state-run hospitals to community residences and ensuring the provision of certain social, educational, and rehabilitative services, DMR decided to purchase the necessary services from non-profit organizations such as SERVESS and DARSO.

Prior to awarding a contract for the provision of such services, DMR elicited bids through a Request for Proposals (RFP). After the contract award, DMR reviewed the service provider's budget to determine the provider's planned expenditures for the contract period. The contract was awarded and

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payments were made based upon regulations promulgated by DMR and the Massachusetts Rate Setting Commission (RSC).

Under the purchase-of-service system, SERVESS and DARSO could seek reimbursement for their actual expenses in providing group homes for DMR's clients. The 114.5 Code of Massachusetts Regulations (CMR) 3.00 et seq governs this reimbursement and requires disclosure of business dealings and transactions with related entities. The purpose of the regulations is to prohibit artificial costs from being added to the true cost. Reimbursement by DMR should have been limited to the actual cost of procuring goods or services.

This audit report describes how SERVESS and DARSO violated these regulations and identifies alleged fraudulent requests for reimbursement by SERVESS and DARSO filed annually with the Commonwealth.

Based upon evidence developed by the OSA and U.S. Postal Service Inspectors and presented to a federal grand jury by the United States Attorney, indictments were returned against the two founders of SERVESS and DARSO and a trustee of five realty trusts. Indictments alleging mail fraud, racketeering, and aiding and abetting were returned against the two founders; five realty trusts that purchased and leased property to SERVESS and DARSO; the trustee of the five trusts; a furniture company; and two management companies controlled by the three individuals. The indictments allege, among other things, the manipulation of SERVESS and DARSO by the three individuals in a series of related schemes and artifices to defraud. According to the indictments, the three individuals, in executing the various schemes to defraud,

- A. Set up a management company, CSI, to manage SERVESS, ostensibly as part of an arm's-length transaction;

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- B. Bought or leased homes through five different real estate trusts and then leased the homes at a profit to SERVESS and DARSO, hiding their ownership from the state; and
- C. Set up a furniture company, Underwood, and a second company, TALL Enterprises (TALL), to buy furniture at wholesale and then pass the furniture through one or both of these corporations, inflating the price at each step before selling the furniture to SERVESS and DARSO.

We are referring this report to the Internal Revenue Service, the State Department of Revenue, Division of Purchased Services, DMR, and the Attorney General for their review.

Audit Scope, Objectives, and Methodology

Initially, we focused on the allegations that SERVESS and DARSO made excessive purchases of furniture and paid questionable management fees to CSI. As questionable transactions were detected, we then expanded our scope in accordance with generally accepted government auditing standards, to include an audit of CSI.

Based upon the preliminary findings, the United States Attorney was granted by a federal magistrate a warrant to seize the records of SERVESS, DARSO, CSI, Trescott, Underwood, and the five realty trusts. After a review of these records, we further expanded the scope of the audit to include all the transactions between SERVESS and DARSO and the non-independent, related companies CSI, Trescott, Underwood, and the realty trusts.

We examined contracts that the Commonwealth had with SERVESS and DARSO for fiscal years 1985 through 1989. Using the seized records, we expanded our scope to include all non-arm's-length transactions between the aforementioned companies.

We reviewed cash receipts and disbursements, payrolls, contracts, inventory and purchasing practices, and financial statements. Additionally, we reviewed Articles of Incorporation for SERVESS, DARSO, CSI, and affiliated

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corporations, and the minutes of SERVESS, DARSO, and CSI meetings. We also considered whether SERVESS and DARSO complied with the Department of Mental Health's (DMH) and DMR's contracts and the RSC's regulations concerning reimbursements.

Whenever we detected unusual and questionable transactions, we asked for supporting documentation, such as invoices, vouchers, contracts, and cancelled checks, to determine whether the transactions were appropriate. We also reviewed the seized records and additional supporting documentation subpoenaed by the United States Attorney.

We also interviewed various management personnel from SERVESS, DARSO, and CSI to learn the significant accounting applications and to obtain explanations for questionable transactions. We spoke with management personnel from those entities that turned over subpoenaed records to the OSA's custody. Additionally, we interviewed DMR, DMH, Executive Office of Human Services, and RSC personnel, who explained their contract and reimbursement systems in relation to the purchase-of-service system.

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AUDIT RESULTS

The Founders of SERVESS and DARSO Defrauded the Commonwealth of \$1 Million over a Five-Year Period through a Scheme that Exploited the State's Purchase-of-Service System

The founders of SERVESS and DARSO conspired to conceal non-arm's-length, related-party transactions by using intermediary companies and realty trusts that they owned and controlled to artificially inflate the costs reimbursed by the Commonwealth. SERVESS and DARSO, at the direction or under the control of their two founders, hid their partnerships to exploit the state's purchase-of-service system by denying that any transactions occurred with related parties.

The two individuals, in addition to being the incorporators of SERVESS and DARSO, were also closely related to the other entities that dealt with SERVESS and DARSO. A description of those entities and their relationship to the two founders follows:

1. Community Services, Inc. (CSI), a for-profit corporation, provided consulting, accounting, and computer services to SERVESS and DARSO for 10% of their operating expenses. CSI was incorporated by the same two individuals who founded SERVESS and DARSO.
2. Trescott Corporation Trust, Central Street Trust, Bayside Avenue Trust, Bristol County Trust, and Highland Road Trust are all realty trusts that owned facilities leased to SERVESS and DARSO. Collectively, beneficial ownership of these five trusts was shared by the two founders and a third partner. The third partner was designated trustee of each trust.
3. Trescott Corporation, a for-profit corporation, managed the five realty trusts and was the intermediary that received the rental payments from SERVESS and DARSO. Trescott Corporation was organized by the three individuals.
4. Underwood Company and TALL Enterprises, both for-profit corporations, sold and leased furniture to SERVESS and DARSO. Underwood corporate resolutions listed the three individuals as corporate officers. All three individuals were directors and stockholders of TALL Enterprises.

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Trescott, CSI, Underwood, TALL, and the realty trusts existed only to inflate the costs of goods and services passed on to SERVESS and DARSO, which were then reimbursed by the Commonwealth. All transactions between the non-profits--SERVESS and DARSO--and the for-profits--Trescott, CSI, Underwood, TALL, and the realty trusts--were non-arm's-length, and related-party, transactions.

As nonprofit corporations, SERVESS and DARSO could seek reimbursement for their actual expenses in providing group homes for DMR's clients. The 114.5 Code of Massachusetts Regulations (CMR) 3.00 et seq governs this reimbursement and requires disclosure of business dealings and transactions with related entities. The regulations prohibit artificial layers of cost being added to the procurement cost. Reimbursement by the Department of Mental Retardation (DMR) should be limited to the actual procurement cost of any good or service.

Reimbursable operating costs cannot include certain costs paid to related parties. The 114.5 CMR 3.02 defines a related party as:

a person or organization which is associated or affiliated with, has control of, or is controlled by the operating agency or any director, stockholder, partner, or administrator of the operating agency by common ownership. . . .

Related party costs that cannot be transferred to the operating agency are defined in Section 3.13 (8) as:

costs applicable to services, facilities, and supplies furnished to the operating agency by a related party to the extent such costs exceed the costs to the related party of providing said services, facilities or supplies. Costs to the related party shall be allowable only to the extent that they would be allowable if incurred by the operating agency.

Because they made related-party transactions, the three individuals were required to disclose them and the actual procurement cost to both DMR and the Rate Setting Commission (RSC).

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Contracting forms filed by SERVESS and DARSO with the State Comptroller show no disclosure of any non-arm's-length, related-party transactions. Cost reports filed with the RSC show no related-party disclosure made by SERVESS, while the only disclosure made by DARSO for the audit period was the relationship between CSI and DARSO.

During the period of this audit, the Commonwealth compensated SERVESS and DARSO by two methods: (1) direct reimbursement, whereby SERVESS and DARSO submitted invoices and other "proof" of expenses allowed under the contracts, and (2) unit rate, whereby SERVESS and DARSO billed for the number of provided service units multiplied by the unit rate established by the RSC from historical cost data provided by SERVESS and DARSO. Both methods are cost-based and both assume that the vendors are not profiting from the transactions.

As a result of the scheme by the three individuals to inflate and conceal costs, SERVESS and DARSO defrauded the Commonwealth in three general areas: (A) management services, (B) real estate rental, and (C) furniture procurement.

A. Management expenses resulted from a contract with a firm organized by former SERVESS administrators while they continued to act in that capacity. At an August 1984 SERVESS board meeting, the SERVESS board voted to enter into a management agreement with CSI. The two founders were still voting members of that board. (Following the vote to enter into the management agreement with CSI, one of the founders resigned his position on the SERVESS board.) Subsequent to the SERVESS board meeting, the same two individuals, as the only voting members of CSI's board, voted to accept the SERVESS management contract.

CSI's management services included locating facilities and providing furniture for the SERVESS programs. The trustee of the five realty trusts was CSI's facilities consultant. The management expenses paid to CSI by SERVESS

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included consulting costs for the trustee of the realty trusts, lease costs for equipment rental from Underwood and TALL, and lease payments on property rented from the Trescott Corporation Trust. CSI's invoices to SERVESS were marked up, and reimbursement by the Commonwealth for these invoices was inflated by \$450,000 for the five-year period.

B. Real estate lease expenses charged to state contracts resulted from payments to trusts controlled by the former SERVESS administrators. The facilities leased by SERVESS and DARSO were owned by the Trescott Corporation Trust, the Highland Road Trust, the Bayside Avenue Trust, the Bristol County Trust, and the Central Street Trust. The three individuals were all beneficial owners of the trusts. SERVESS and DARSO, at the direction of CSI, typically entered into long-term leases with the realty trusts. The three individuals were able to utilize these leases as collateral for bank financing. The financing terms were typically 15-25 years in length. The leases between SERVESS/DARSO and the respective trusts were usually 10-15 years in length. A number of the leases were executed and lease payments were made by SERVESS prior to the trusts' actually taking ownership of the property. The Commonwealth's reimbursement to SERVESS and DARSO was to be limited to mortgage interest expense, depreciation (33 1/3 years per 114.5 CMR 3.02), and leasehold improvements (20-year amortization per 114.5 CMR 3.02). However, as the beneficial owners of the trusts that leased the properties to SERVESS and DARSO, the three individuals were able to inflate the allowable costs and to add an additional layer of profit to these costs, which resulted in an overcharge to the Commonwealth of \$350,000.

SERVESS leased one property in Attleboro from the Trescott Corporation Trust, even though the trust did not own the property. The trust leased the property from the actual owners for \$850 per month and sub-leased the property

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to SERVESS for \$1,450 per month.

Most of the properties were purchased in the mid 1980s when real estate prices escalated. A number of the trusts' mortgages were rewritten during this period. The proceeds from the various refinancing operations were used by the three individuals through the trusts as down payments on additional properties, including the purchase of a condominium in Florida.

C. SERVESS and DARSO purchased furniture and appliances from two companies, Underwood and TALL, that are controlled in whole or part by the three individuals. Underwood bought furniture and appliances from two retail outlets in southeastern Massachusetts. The goods were delivered to SERVESS or DARSO by Underwood's lone employee in a truck borrowed from one of the retail outlets. Underwood had no warehouse, showroom, vehicles, inventory, or employees, aside from the one delivery person.

Underwood did business only with non-profit human service providers such as SERVESS and DARSO. Underwood's invoices to SERVESS and DARSO were marked up 100%, and reimbursement by the Commonwealth to SERVESS or DARSO for these invoices was inflated by approximately \$200,000 during our audit period--more than double Underwood's purchase price.

Additional Underwood furniture and appliances, not billed directly to SERVESS and DARSO, were invoiced to TALL, which would add an additional layer of inflated cost and lease the furniture to SERVESS or DARSO. The two founders never disclosed their involvement with TALL to Massachusetts; however, they both disclosed an ownership interest in TALL to the state of Connecticut (these two individuals were the founders of a non-profit human service provider in Connecticut) two months after their records were seized in Massachusetts.

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Instead of disclosing these non-arm's-length, related-party transactions, SERVESS and DARSO sought and obtained from the Commonwealth payments exceeding costs by \$1 million, in violation of 114.5 CMR. In addition, the two founders of SERVESS and DARSO gained title to property that appreciated in value.

CONCLUSION

The results of this audit demonstrate the Commonwealth's that purchase-of-service system was vulnerable to fraud, waste, and abuse during the five year period 1985 to 1989. The system was vulnerable because it had no effective, independent means of verifying that service providers were in fact dealing at arm's length with their suppliers. The 400 independent audits (of over 1400 providers) reportedly conducted by the Executive Office of Health and Human Services during this five-year period did not provide a sufficient level of oversight to prevent abuse of the Commonwealth's purchase-of-service system. The Commonwealth's primary assurance of provider compliance came from the providers themselves. The principals of the SERVESS and DARSO scheme were able to defeat the system by simply not declaring that they were dealing with related parties.

Recent news articles as well as ongoing audits indicate that the concealment of related-party transactions is extensive and widespread.

We also found that program administrators feared that providers would reduce the level of care when budgets got tight and that providers would, without warning, close their facilities. Because the facilities are owned or leased by the contracting provider, the location of services would have to change, a disruption that program administrators believe would severely disturb most clients and would likely set back years of client progress that has taken thousands of dollars to achieve. This fear may have discouraged program staff from desiring close financial monitoring.

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The primary oversight and regulatory functions of the state's purchase-of-service system was transferred in July 1990 from the Executive Office of Health and Human Services (EOHHS); the Rate Setting Commission, which reports to EOHHS; and EOHHS purchasing agencies to the newly established Division of Purchased Service (DPS) in the secretariat of the Executive Office for Administration and Finance. DPS assumed primary responsibility for the implementation and coordination of an efficient and accountable system of procurement; selection; pricing; contract administration; program monitoring and evaluation; contract compliance; and post audit for any department, agency, board, or commission of the Commonwealth that procures or pays for social service programs from providers.

DPS established new provisions in 1991 for reporting financial information and disclosure of related-party relationships. The reporting of financial information was shifted from the unaudited RSC 1100 cost report to an audited document that included basic financial statements, to be prepared in accordance with the AICPA Industry Audit Guide "Audits of Voluntary Health and Welfare Organizations", audited in accordance with generally accepted government auditing standards, with four supplemental schedules that report costs by program, submitted in accordance with AICPA auditing standards.

This new reporting document, entitled the Uniform Financial Statements and Independent Auditor's Report (UFR), is utilized annually and is intended to add a much-needed audit element to the purchase-of-service system. In addition, DPS implemented five levels of disclosure of all related-party relationships and transactions in Commonwealth-funded programs. These disclosures, when certified, place the organization's Board of Directors under penalty of perjury to acknowledge that all related-party relationships and transactions have been disclosed. The Board of Directors must disclose

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related-party relationships and transactions in proposal submissions, in Standard Service Contracts during contract negotiations, in the certified Affidavit of Compliance of the Master Agreement, in the certified Contracting and Ready Payment Prequalification form during contract prequalification for new programs and contract renewals, and in the notes to the financial statements and Board of Directors' acknowledgment letter of the UFR.

The state's purchase-of-service system has been revised within the past year from a strictly unit rate-based system (i.e., relying on each provider's assertions of "true and actual" costs made directly to the purchasing agency or on each provider's submissions to the Rate Setting Commission) to a system that bases reimbursements on "reasonableness" rather than on costs alone. Rates are no longer established by purchasing agencies and approved by the Rate Setting Commission. The Division of Purchased Services (DPS) assumed the oversight function for human services purchased by the state. DPS is now gradually implementing a mechanism that measures reasonableness for budgeted costs that are negotiated during purchasing agency contract negotiations by comparing the provider's costs to industry norms. These norms are established by compiling specific data that are currently available through statistically valid market surveys of the costs of organizations and individuals (e.g., private day care workers, nursing home employees, state employees, private case managers, and care givers) providing similar services but that do not contract with the Commonwealth.

DPS still obtains cost data from each provider's UFR, which is used to verify changes in provider resource usage and to adjust future norms, if appropriate. DPS has even more information than that which the Rate Setting Commission used for approving rates. Further, because it now has a reasonable range of prices that purchasing agencies are free to negotiate within, the

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Commonwealth is less likely to pay less or more than that which is required to meet the needs of clients and the citizens of the Commonwealth.

The Commonwealth's annual expenditures through the purchase-of-service system have risen to more than \$2 billion and will increase further as the state moves to privatize services that traditionally have been provided by the state itself.

SUBSEQUENT EVENTS

On April 30, 1992, the trustee of the five realty trusts pled guilty to one count of racketeering.

The two founders of SERVESS and DARSO each pled guilty to 14 counts of mail fraud stemming from their roles in 14 separate schemes to defraud the Commonwealth of Massachusetts of more than \$500,000. Each mail fraud charge includes a penalty of payment of restitution. Sentencing for both is scheduled for March 1993.

On December 1, 1992 the former acting Area Director for the Department of Mental Retardation's Attleboro Office was indicted on five counts of bribery in violation of United States Code Section 666. The bribe was received in conjunction with the award of a 1986 day habilitation program to DARSO. The former acting Area Director had responsibilities relevant to the award of DMR contracts within the Attleboro area for the provision of day habilitation services to the mentally retarded. The indictment alleged that during the bidding process the former acting Area Director sought from DARSO (one of the three bidders) employment for his wife in the day habilitation program. The founders of DARSO agreed, and, following the award of the contract to DARSO, that company employed the former acting Area Director's wife in the day habilitation program and in two other programs run by DARSO.

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On December 9, 1992 DARSO filed a voluntary petition with the United States Bankruptcy Court for protection from debtors under Chapter 11 of the Bankruptcy Code. DARSO listed total liabilities of \$939,303 and total assets of \$531,383 as of September 30, 1992. This is the second Chapter 11 bankruptcy filing by DARSO in Massachusetts within the last six years.

After learning of the December 9, 1992 filing, we requested and received from DARSO copies of fiscal year 1992 financial statements and minutes of the March 5, 1992 and June 24, 1992 board meeting, which state in part:

Board of Directors Meeting Minutes:

March 5, 1992

13. Golf Course

"Mr., (the current executive director), announced that he has taken out a golf course membership on behalf of the agency at an initial cost of \$872 and annual cost of \$372. Mr. mentioned that this is for PR purposes and that board members are invited to use this membership."

16. Contract Negotiations

- e. "Mr. can borrow against accrued vacation time to the limit, in dollars, of said actual obligation. Borrowing must be repaid in monthly installments and by contract of not more than two years."

**Executive Board Meeting
June 24, 1992**

6. "Mr. asked that the minutes of the last meeting of the board be amended, when referring to Mr. (the current executive director's) loan to read, refer only to accumulated vacation time, not vacation and sick time."

On April 3, 1992 the executive Director was advanced approximately \$12,000 for accrued sick days. The June 24, 1992 executive board meeting amended the April 3 minutes to designate the advance as accumulated vacation time and not sick time.

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Prior to this filing, the Department of Mental Retardation had notified DARSO that the Commonwealth of Massachusetts would be terminating all existing contracts on December 31, 1992.

Attached to the November 1990 indictment of the SERVESS and DARSO founders was a civil complaint against the founders, their business partner, the Trescott Corporation, and the five realty trusts pursuant to 18 U.S.C. section 1345. The result of the civil complaint was an injunction directing the non-profits, SERVESS, and DARSO to make lease payments into an escrow account. The fiduciary of the account, an Assistant United States Attorney, was responsible for making Trescott's mortgage payments. To date the account has a balance in excess of \$100,000, which will be turned over to the Commonwealth.

Waste, abuse cast cloud over state's privatization program

First of five parts

By DAVID ARMSTRONG

William Wolk oversees the spending of \$4 million a year in state funds.

His job is to admin-

ister residential and job programs for the handicapped and mentally retarded on the South Shore.

For his work, he is paid \$115,000 a year, en-

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PUBLIC SERVICES



LIFE & BUSINESS: WELSH: CLARENCE MORTIMER

THE BOSTON HERALD, TUESDAY, FEBRUARY 16, 1989

Privatization proves no

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From Page 1

joys the use of a \$40,000 BMW — most of it paid for by taxpayers — and is reimbursed for the cost of insurance premiums and other expenses, according to state records.

In William Wolf yet another one of those but slightly paid and lavishly perked state bureaucrats Gov. William F. Weld is trying to eliminate through privatization?

On the contrary, William Wolf is an example of privatization.

He's president of the non-profit Work Inc., a Quincy-based company hired by the state to provide services to some of the commonwealth's neediest residents.

And Wolf is hardly alone.

More than 1,400 private, mostly non-profit agencies are paid more than \$1.2 billion by the state each year to provide a range of human services — from foster care and homes for the mentally retarded to programs for delinquent youths.

Under Weld, these private vendors have become the state's front-line provider of human services, and the shock troops in the governor's campaign to further privatize state services — part of his goal of creating an "entrepreneurial government."

The governor and his key aides argue that in most cases, private businesses can assume the functions once performed by state agencies at lower cost, and with greater efficiency and better results.

"We are saddled with bureaucracies 30 years out of date, sluggish and centralized, in which hierarchies rule and orders are issued from the top of a power pyramid," Weld said in his 1991 inauguration speech, which laid out his intention to establish a leaner government.

But a four-month Herald investigation of how some private providers are spending money and operating their businesses raises troubling questions about the extent of waste, abuse and fraud in the world of privatized human services.

While state officials and vendors insist that a "few bad apples" are spoiling the reputation of an otherwise decent industry, the Herald discovered that:

• Non-profit companies with long histories of shoddy care and financial abuses continue to do business with the state. In some of these cases, state offi-

cials are aware of the problems, but have taken no action.

• Many top administrators of non-profit human service agencies receive extravagant salary and perk packages that are unheard of in state service. Some agencies have even purchased Florida vacation homes.

• The state has only four auditors responsible for routinely monitoring the finances and tax returns of hundreds of state contractors. Private certified public accountants — hired and paid by the state vendors they are supposed to audit — now perform almost all financial checks for the state.

• Loose controls often result in boards of directors stacked with friends and associates of agency administrators, creating an atmosphere in which the impartial oversight required of non-profit boards is non-existent and patronage and fraud flourish.

• Top state managers frequently move from their government jobs to positions with state contractors and back again in a revolving door whose velocity blurs the line between watchdog and watched.

• Many human service providers are teetering on the edge of bankruptcy.

• The state is allegedly being bilked by some providers who use related corporations to purchase expensive perks or shield illegitimate costs from the eyes of regulators.

• The state, backed by numerous studies, asserts privatization is saving money, but other experts contend the philosophy may ultimately cost taxpayers a bundle and leave the state hostage to private contractors who will be providing the bulk of services.

• Internal state memoranda indicate state officials are often

more concerned with protecting the philosophy and image of privatization than with cracking down on bad vendors.

For many non-profit human service providers in Massachusetts working for the state has become an unrivaled financial bonanza.

"Andrew Jackson would have loved this system," said state Rep. Marie Parente (D-Milford).

a critic of Weld's human service privatization. "This is the greatest spoils system known to modern times."

□□□
If anyone doubted the Weld administration's commitment to

privatization, they should have been convinced in June 1991 when a panel created by the governor recommended the closing of nine state human service facilities.

Today, most of the six state



STREAMLINING: Gov. William F. Weld, the driving force behind the privatization of human services in the commonwealth, argues that private businesses can perform the function of state agencies at a much lower cost.

PHOTO BY THE PRESS

panacea

hospitals and schools for the mentally ill and retarded, and the three public health hospitals targeted by the panel, are empty.

The state claims the closings will result in a \$30 million savings on operating costs alone — a figure that has been disputed by advocacy groups and state employee unions.

Weld is actually accelerating a trend that first arose in the 1970s, when eager advocates armed with a federal court order forced the state to make speedy improvements in the then subhuman treatment of the mentally ill and retarded.

One solution hit upon at the time was to transfer patients out of dilapidated state hospitals and schools and place them in the care of private organizations operating modern group homes, day programs and activities.

The buy rather than provide philosophy has been wholeheartedly adopted by the Weld administration and is now on the fast track as part of the governor's plan to trim expensive state employees — while he has dubbed "wastefulness" — and improve the efficiency of state government.

Proof of Weld's desire to swiftly privatize human services can be seen in the numbers.

The number of executive branch employees, where all human service agencies are located, was down from 47,700 when Weld took office in January 1991 to 42,963 at the end of 1992.

The current private vendor work force working as the result of state contracts, meanwhile, is estimated at 10,000 to 15,000 employees, according to the state.

In 1971, a meager \$28 million was spent by the state to purchase human services.

The figure jumped to \$611 million in 1985 and stands at more than \$1.2 billion today.

Money spent on state institutions, such as schools for the mentally retarded and hospitals for the mentally ill, has decreased under Weld.

The recently proposed fiscal '94 budget, for instance, cuts funding for institutions by \$49.6 million from Weld's first year in office.

At the same time, funding for community programs, largely provided by private agencies, has increased dramatically by \$19 million since Weld first took office.

These numbers promise only to grow as top Weld aides continue to search out private alternatives for services once provided by the state bureaucracy.

"To the extent someone can capture and operate a private entity under a different set of rules, and that works to the state's advantage, we would be wise not to take advantage of it," said Health and Human Services Secretary Charles Art.

□□□

Drawing a distinction be-

tween human services the state buys and human services the state provides is not always easy.

In fact, there exists a cozy world in which skilled professionals and top administrators frequently shuttle between work at state agencies and jobs at the private agencies receiving millions in state contract dollars.

In many cases, state officials charged with safeguarding taxpayer dollars spent by private human service agencies end up leaving the state and taking jobs at those same agencies.

This perpetual revolving door creates a world where the line between purchaser and contractor is often blurred.

There are dozens of state officials who have used their inside knowledge of how contracting works to secure lucrative contracts for providers they went to work with," said Cliff Cohn, the co-chairman of the Partnership for Quality Care, an anti-privatization group.

"They are making a profit from their knowledge," Cohn says. "The examples of the revolving door are numerous."

As a state DMH employee, Linda Bimto monitored contracts the state had with the Greater Lynn Mental Health and Retardation Association Inc. She left the state in December

Human Service Revolving Door



Arrows indicate which way the worker has moved between state service and state contractor positions.

NAME	STATE SERVICE	STATE CONTRACTOR
Eve Youngerman	Dept. of Youth Services	Meritor Inc.
Andrea Goode	DYS	NE Family Institute
Stephen Day	Deputy Commissioner, DMH	Justice Resource Inst.
James Murphy	Exec. Office of Human Services	Vendor state consultant
Andrew Brozman	Clinical Director, DMH	Deaconess Hospital
Philip Campbell	DMH Commissioner	Director of ARC FSS Inc.
Frederick Mello	Deputy DMH Commissioner	Worcester Area ARC board
Paul Cox	EOHHS chief of staff	Center for MR and MH
Roger Davies	Area Director, DMH	Victor Corp.
Kenneth Larnard	State Rep.	Charles Rose West
Greg Torres	Sen. Ways and Means Comm.	Mentig Inc.
John McManus	DYS Commissioner	Procter Council
Melvin Spovett	Ass. Welfare Commissioner	Spovett & Schwager
Miles Shore	Mass. Mental Health Center	Vinfin Corp.
Richard Dougherty	DSS	Private vendor consultant
Harry Shuman	DMH	South Shore Mental Health Ctr.
Linda Bimto	DMH	Grassie Lynn MR and MH
Larry Art	DMH	Dorchester Counseling
Ann Unger	School Superintendent, DMH	Assoc. for Community Living
Daniel Fletcher	Former Secretary, EOHHS	VP Lutheran Services
Janet George	Undersecretary, EOHHS	Pres. Lutheran Services
Valerie Fletcher	DHS	Algonia for Mentally Ill
Peter Nessen	Secretary-A & F	800 Sedman/Vinfin Corp.

Not graphically shown



Joining state service. While a state employee he oversaw the awarding and monitoring of contracts to Vinfin.

It is in this comfortable atmosphere that a number of unusual arrangements exist.

DMH Commissioner Eileen Elias, for instance, signed off on a deal that allows the relative of an executive at a large state provider to work summers at a state-run Cape Cod mental health center.

Dr. Al Flashman has worked at the Pocomet Mental Health Center during the past four summers. He lives in Israel the other part of the year and brings his family to Cape Cod with him during the summer months, DMH spokesman Mary McGovern said.

Flashman is a relative of Melvin Boovell, a principal in Boovell & Schwager, one of the largest human service vendor agencies in the state.

His summer work is paid by Boovell & Schwager as part of a state contract approved by Elias when she was DMH area director for Cape Cod.

McGovern defended the arrangement, citing the difficulty inherent in attracting top professionals to work on the Cape.

"In general, it is hard to recruit doctors down there," she said. "There is no academic institution to affiliate with, and when he first came Pocomet had lost its certification."

For each of the first three summers, Flashman was paid \$21,600 for two months work.

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UNDER FIRE. Administration and Finance Secretary Peter Nessen, above left, the architect of the drive to privatize human services, is a frequent target of privatization critics, including Rep. Mark Parione (D-Holbrook), above right, and Cliff Cohn, co-chairman of Partnership for Quality Care, an anti-privatization group.

Parione (top right) and Cohn (bottom right) are frequent targets of privatization critics.

1990 and turned up a year later at none other than Greater Lynn.

Larry Art, the former center director of the DMH Dorchester campus, left his state job

July 27, 1991 to take an administrative position with the Dorchester Counseling Center. While employed by the state, Art oversaw the agency he now works for.

Roger Davies was the Department of Mental Retardation area director for Greater Boston. He left his state job in September for a post at Vinfin Corp., where he worked prior to

Weld's highly touted privatization plan

From Page 7

Last summer he worked only part time and was paid \$13,200, according to DMH records.

In addition, another major vendor is actually paying the salaries of some state administrators at the DMH. And several DMH employees, paid by the state, are actually working for vendors. (See related story, Page 6)

The perpetually revolving door and the close relationships between vendors and state officials are now being reviewed by Baker, the state's top human services official.

"I think the revolving door is a problem if you don't address it and establish some fairly rigid and tangible guidelines for how people use it," he said in a recent interview.

There are currently some restrictions on state employees going to work for contractors they may have overseen or negotiated with while in public service.

However, many of the regulations are vague and inadequate. Punishing violators of these policies is also extremely

difficult because of a lack of witnesses and information.

No matter what changes the state may make to stem the ebb and flow of job switches, some in the business say these types of moves are inevitable.

"Our skills are honed to working with people and few industries are working with people other than the state and ourselves," said Sheldon Bycott, the president of Vindén Corp., the largest state human service contractor. "By the nature of it you get this revolving door."

□□□

The often snug relationship between the state and its contractors starts at the top, critics of privatizing human services allege.

Chief among their targets is the architect of the Weld drive to privatize human services — Attorney Peter Nesen.

Nesen burst on to the government scene in 1990, when after three years of work for the Dukakis administration, he released a report warning that the contracting of human services had become a "black hole."

tions, many of which were adopted by the Dukakis and Weld administrations, have been controversial.

He spurred the creation of the Provider Lease Program to help private human service agencies acquire needed capital.

Under the plan, the Massachusetts Industrial Finance Agency offered tax-exempt real estate loans to human service providers seeking to acquire needed buildings.

The idea was to allow providers to pay a fixed yearly lease amount over 20 years to avoid suffering from rapidly escalating rent payments every year. At the end of 20 years, the provider would own the property.

The program suffered, however, when it became known that Nesen's brother and a Nesen colleague had benefitted from its creation.

The law firm of brother Robert Nesen served as the bond counsel to MIFA for the lease program, reaping a reported \$100,000 in fees.

In addition, a former state government colleague of Peter

Nesen, Bernard J. Rudman, also profited from the provider lease program.

He was paid \$90,000 by MIFA to manage the properties acquired by providers under the lease program.

A state audit of the program last year termed the Rudman involvement a "questionable activity" and noted Rudman worked with Nesen during the Dukakis administration to design the provider lease program and promote it among providers.

The controversy over the provider lease program angers Nesen to the point where he cuts short conversation about it.

"If you have something in particular you want to discuss, bring it up, but otherwise I don't want to waste any more time on it," he said in an interview with the Herald.

"I think there was innuendo that was uncalled for," he said before ending the lease program conversation. "If someone has a legitimate gripe it hasn't come to fore."

Nesen is also bothered by

PUBLIC SERVICES



"micromanagement" by the state; a revamping of the pricing structure for services; and a switch from the policy of performing state audits of providers to one of leaving them to private Certified Public Accountants hired by the providers.

On the campaign trail, Weld frequently cited the Nesen report as a blueprint for overhauling the state's massive human services system.

Some of Nesen's sugges-

seems fraught with waste, abuse & fraud

charges, made primarily by state employee unions, that he is biased in favor of private human service providers.

The allegation is based on Neesen's work experience outside government in combination with his fervent push for more privatization of human services.

Neesen left the Dukakis administration in 1990 and joined the tax-exempt and government services division of the Boston office of the accounting firm RDO Seidman.

In this job, Neesen worked for several non-profit human service providers doing business with the state. A colleague in the government division was Thomas McLaughlin, a former top official of the Massachusetts Council of Human Service Providers, a lobbying group for state contractors.

McLaughlin also served as a consultant to the state purchasing office created as a result of Neesen's changes.

Before joining the Weld Administration, Neesen also served on the board of directors of Vincen Corp., the largest state human service contractor.

"Peter Neesen worked for a firm that sold human service vendors cart blanche," said John Gatti Jr., a spokesman for the Massachusetts Organization of State Scientists and Engineers, an employee union.

"He has led the charge for lesser accountability."

The charge, however, annoys Neesen.

"This is ridiculous," he said. "I am here because of my back-

ground and I'm proud of it. I am looking at and challenging the system and I will continue to do so."

He also challenged the unions to point to specific actions of his to support their bias claim.

March 1 to become dean of resources and special projects at the Harvard Medical School.

His connections to the medical school have not helped his main service as administrator and finance secretary.

The dean of administration at the medical school, David

Bray, served on the Vincen Corp. board with Neesen.

Tomorrow: Although private human service providers are living the high life with lavish pay, fancy cars and extravagant perks.

Donna H. Baker 0.46
2-13-93 Saturday

40 THE BOSTON GLOBE • SATURDAY, FEBRUARY 13, 1993

State to sever contracts with provider of services to retarded

By Victoria Benning
GLOBE STAFF

The state has moved to suspend business with one of its largest providers of services for the mentally retarded for at least a year because of allegations of overbilling and other contractual improprieties, officials said yesterday.

Charles Baker, secretary of health and human services, has notified the Center for Humanistic Services, Inc. that he is proposing to suspend the agency from doing business with the state. The suspension, if carried out, would bar the center, its executives, and related parties from holding any state contracts.

The state inquiry, and a related federal investigation, were launched after the Globe Spotlight Team disclosed alleged financial irregularities and questionable business dealings at the Center for Humanistic Services in a 1991 series.

Judith Cross, a Springfield attorney representing the center, said her client will appeal the proposed suspension and will request a hearing on the issue.

"I am absolutely convinced that we are going to prevail," Cross said last night.

Baker said in an interview that the move to suspend the center is a state contractor follows a

"long and complicated history" of inquiries into the center's operations by several agencies. The suspension is based on a new state law, proposed by State Auditor Joseph DeNucci, which simplifies the public contract debarment process.

The center, which holds about \$5.4 million in contracts to provide a variety of services for more than 300 mentally retarded clients in western Massachusetts, is the subject of a federal investigation. The agency had most of its files seized in April of last year when federal agents raided its offices.

The center has been a state contractor for 12 years.

The Spotlight Team reported that, over five years, the center had funneled close to \$1 million in state money into companies owned by the center's three founders. The Globe also found that the center did not disclose to the state its ties to realty trusts and an equipment and car rental company, with which they subcontracted for services, an action that appeared to violate state related-party disclosure requirements.

State regulations limit vendors to reimbursements of "actual costs" only when they do business with an acknowledged related party.

The center's founders, Albert J. Dias, C. Thomas Campagna and Louis Gallinaro, also own

Executive Management Associates, a money-lending and management firm that oversaw the operations of the center and billed the center for questionable expenses, according to the Spotlight investigation.

Cross said last night that there has never been any official finding confirming the related-party allegations and that an independent auditor hired by the center last October "found absolutely no evidence of related-party relationships."

The state did not immediately move to suspend business with the center. Investigations were just getting under way and finding another provider in western Massachusetts that could care for 300 retarded persons was difficult, according to Philip Campbell, the commissioner of the Department of Mental Retardation.

But upon further investigation by the state auditor and US attorney's office, the Department of Mental Retardation recommended the contract be suspended.

"The department has since concluded that CHC continues to demonstrate it lacks the business integrity and honesty to remain a public contractor with the commonwealth," Campbell said. "We have found that CHC continues to provide incomplete and or misleading responses to direct and specific questions."

Payroll allegiance blurs for 2 state officials

Herald P.6 - 2-16-93

The state's largest private human service contractor has, at different times, paid the salaries of two high-ranking Department of Mental Health administrators, according to DMH records.

This unprecedented arrangement constitutes a blatant conflict of interest for one of the officials, whose job responsibilities include monitoring the contracts of the vendor who pays his salary, Vinfen Corp. of Boston.

The official, Jean Wilkinson, was on the Vinfen payroll while performing his state duties from December 1991 to April 1992, according to the DMH. When the DMH central office learned of the arrangement, Wilkinson was ordered to rejoin the state payroll.

Wilkinson is the assistant director of community pro-

grams at the Fuller Mental Health Center and oversees the work of Vinfen.

A second official, Richard Dropski, has been paid by Vinfen since April 1992. He was placed on the company's payroll after being laid off from his job as an administrative specialist at the Lemuel Shattuck Hospital.

He continued, however, to perform his state duties while on the Vinfen payroll. He did not directly oversee any Vinfen contracts.

DMH spokeswoman Mary McGeown said Dropski has been notified he must rejoin the state payroll or lose his Vinfen-funded position.

McGeown said DMH officials were not aware of the Dropski arrangement until asked about it by the Herald. She described both situations

as inappropriate.

"This never should have occurred ... (and) is simply unacceptable," she said. "It has been going on far too long."

Vinfen is also paying the salaries of 13 psychologists who were laid off by the state in 1991 and 1992, but continue to perform the same functions they did as state employees.

The practice by taxpayer-funded contractors of paying laid-off state employees to continue to work raises questions about the practical effect of cuts in the public workforce by the Weld administration.

While the number of state employees has declined since Weld was elected, the number of employees working for state contractors remains virtually unknown — the state doesn't have a specific figure.

One estimate puts this private provider workforce at 66,000 employees, larger than the entire executive branch workforce under the control of Weld.

The tangled relationship between the state and the agencies it hires to provide human services also extends to the Department of Mental Retardation.

At least 104 DMR employees are actually working for vendor agencies, while their salaries are paid by the state.

DMR Commissioner Phillip Campbell said this arrangement existed before the split of the DMR and the DMH in 1987.

He had no explanation for the arrangement, but said he is reviewing the situation.

— DAVID ARMSTRONG

Soaring exec pay robbing the system

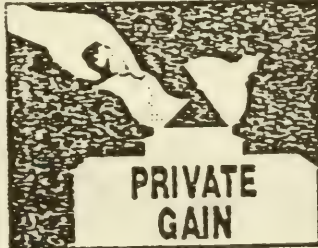
Second of five parts

By DAVID ARMSTRONG

For Warren Davis, 1992 was a very good year.

The executive director of the Center for Hu-

PUBLIC SERVICES



man Services in New Bedford pulled in a total of \$157,599 in salary and benefits during that fiscal year.

Davis' compensation package was a whopping \$67,163 more than what he was paid the previous year for his work.

Turn to Page 12

Execs live high life on state



WHERE'S IT GOING? A state auditor's draft report alleges that state funds paid to Work Inc. of Quincy for services to the handicapped have been diverted to other corporations.

PUBLIC SERVICES



From Page 1

at the agency, a non-profit mental health and substance abuse center.

Davis said the increase was the result of a vacation time buyout, a slight increase in salary and his decision to cash in a deferred compensation plan.

The amount of money Davis made in 1992 could have been generous in private industry. But it was paid by money that represents 1 percent of the \$14 million in revenue from taxpayers.

For critics of Gov. William F. Weld, Davis is further evidence of the 1992 pivot to Davis as post another example of waste and abuse in the system designed to replace an allegedly failed and corrupt state administration.

"The private administrators pay themselves as much as they possibly can because there is no one watching the money strings," said Ed Felt, chief coordinator of the "Partnership for Quality of Care," a group fighting privatization.

"There are many executives paying the most over \$100,000 a year, which is a lot more than what a state manager would make doing comparable work."

High executive pay is just one of an array of perks enjoyed by the agencies. A private, non-profit agency doing \$12 billion in human service contract work with the state every year.

While these agencies are funded by taxpayers to provide care for some of the state's neediest residents, many of these hard-to-come-by dollars — both private and state — are used for controversial purchases.

A four-month Herald investigation found that:

- Many executive directors lease or purchase expensive luxury automobiles — with state funds — in some cases for their personal use. The vehicles include Lincolns, BMWs and Mercedes.

- Three agencies purchased Florida vacation homes.

- One agency built a private petting zoo, stocked with llamas, a buffalo and a camel.

- Such perks — unheard of at even the highest levels of state government — are parceled out in a system in which conflicts of interest are abundant and insider deals are tolerated.

- Some private, non-profit agencies have handed out contracts to members of their boards of directors — potentially compromising them in their duty to act as law enforcers and advocates for the needy clients receiving services.

- Millions of dollars are also exchanged between state contractors and related corporations not monitored or audited by the state. Transactions that effectively hide the way state dollars are spent.

- In several cases, these arrangements have resulted in waste, fraud and abuse.

- Checks and under dealings are frequently absent from required government documents as a result of "outstanding" reporting requirements.

- And unlike the heads of large state agencies and institutions, the directors of private human service agencies dependent upon the state for their existence seldom worry about conflict of interest laws, state bidding regulations, open meeting or freedom of information laws, and general financial disclosure requirements.

- They don't apply.

- If you are a state employee, you have all kinds of regulations for financial disclosure, and law (with privatization)," said Lawrence Overhaug, a conservative researcher who has studied human service privatization.

- "There is a major problem with accountability."

DIRECTORS OF STATE HUMAN SERVICE CONTRACTORS EARNING MORE THAN GOVERNOR

ORGANIZATION	NAME	COMPENSATION
Center for Human Services Inc.	Warren Davis	\$149,588
South Shore Mental Health Center	Harry Shulman	119,000
May Institute	Walter Christan	117,513
Vinten Corp.	Sheldon Byloff	116,000
Work Inc.	William Wells	115,000
Crystal Springs School	Charles Young	113,000
Morgan Memorial Goodwill	Deborah Jackson	111,384
Scovell & Schwoiger	Melvin Scovell	110,000
Scovell & Schwoiger	Charles Schwoiger	110,000
Judge Baker Children's Center	Gloria Johnson-Powell	110,000
Health and Human Services Management Co.	Kathleen Whight	102,536
Greater Lynn Mental Health and Retardation	Albert Bieau	101,993
Boston Children's Services	Richard Jones	101,000
Mass. Society Prevention of Cruelty to Children	Joyce Storm	101,000
Fair Academy	Not available	100,539
Behavior Resource Institute	Matthew Israel	96,169
League School of Boston	Herman F. Shoben	93,532
Justice Resource Center	Susan Wayne	90,000
Metrowest Mental Health Association Inc.	Not available	88,817
Eagleton School	Bruce Bona	85,000
Massachusetts Mental Health Research Corp.	Alan D'Amico	85,000
Integrated Services Inc.	William Polis	85,000
Center for Human Development	Robert Fazzi	84,171
Germane Lawrence School	Not available	82,878
Key Program Inc.	Not available	82,625
North American Family Institute	Yezha Bakal	82,373
Goodwill Industries of Springfield/Hartford	Not available	81,450
Evergreen Center Inc.	Not available	81,346
North Suffolk Mental Health Association	Eugene Thompson	79,865
New England Residential Services	Michael Worthen	79,801
Mass. Council of Human Service Providers	John McManus	78,575
North Essex Community Mental Health Services	Frank J. Karlos	77,377
Center for Mental Health and Retardation	Ellen Altavides	75,000
Governor of Massachusetts	William Weld	75,000

Source: State Division of Purchased Services and State Attorney General's Public Charities Division

Herald staff graphic.



SHELDON BYLOFF
Defends directors' high pay

DOCI

Warren Davis is not the only highly compensated private human service executive in the state.

In fact, a Herald examination of human service agencies doing business with the state uncovered more than 30 executives whose pay surpassed that of Gov. Weld, who makes \$75,000 a year.

Many of the executives reported steady — and in some cases lavish — increases in pay during the past five years.

At the Center for Mental Health and Retardation Services

Inc. in Watertown for example, which received \$16 million in state money in fiscal 1991, the pay of the executive director nearly doubled over three years — skyrocketing from \$57,000 in fiscal 1986 to \$111,000 in fiscal 1991, according to state records.

The large amounts paid to private human service executives are a stunning contradiction of one of the primary arguments for privatization: the elimination of "expensive" and ineffective state bureaucrats' inflated salaries.

Byloff on the compensation of And while these executives are generally well compensated, the front line workers providing care to state clients are dramatically underpaid.

This year, for the fourth straight year, the state has decided not to fund a cost-of-living increase for direct-care workers at private agencies doing business with the state.

But the state dictates only the pay of front-line workers, while allowing executive directors to draw as high a salary as they wish.

A computer analysis of a state database containing human service contract information indicates the average lower level direct-care worker earns \$17,892 a year.

Meanwhile, the average agency director earns \$100,000 a year, according to the database.

State officials and the directors of private agencies acknowledge that front-line employees are "usefully underpaid."

"I couldn't agree more," said Warren Davis. "Private human service officials complain that directors are underpaid."

But what about the workers? And direct-care workers barely get paid from the funds of state officials to recognize a fair wage for their employees.

Diane Rosenbaum, director of the State Division of Purchased Services, said the state is trying to improve direct-care pay by revamping the bidding process for human services.

While Rosenbaum talks about upgrading the pay of low-end employees, executive pay has grown unchecked. Rosenbaum said the salaries of executives is something he wants to examine.

Others think the time for such an examination is overdue.

"I have been battered in general for years by the enormous discrepancy in pay between the state and industry in private labor," said Secretary of Health and Human Services Charles Baker.

taxes

When hundreds of human service agency employees gathered at the Weston Hotel in November for their annual convention, the sensitive subject of executive salaries was on their minds.

It was no surprise, then, when lawyer leading a seminar at the convention — sponsored by the Massachusetts Council of Human Service Providers Inc. — provided some helpful hints on how to avoid public scrutiny of high executive salaries.

Robert Cowden, the legal counsel to the provider organization, lectured on the advantages of setting up a for-profit subsidiary.

Among the chief advantages were flexibility in compensating executives.

The untold advantage of a for-profit subsidiary, in that the instrument does not require the kind of public filings from for-profit corporations that it does from nonprofit agencies. Hence, under a profit-making subsidiary, the salaries of top nonprofit executives can be hidden from public view.

Those who do reveal their salaries forcefully defend their compensation.

"You honestly have to pay people to manage and assume the real responsibilities of running nonprofit organizations," said Vivien Trep a Byoff, who operates an agency receiving \$24 million a year in state money. "There is a market that dictates what you have to pay."

John McManus, executive director of the provider council, told "Unlike public managers, these executives bear full fiduciary responsibility for their own organizations. They do not have the state deficiency budget process to bail them out if they run out of money."

Despite McManus' assertion, the state has attempted to bail out some failing private providers.

McManus also said surveys have determined the pay for executive directors at human service agencies is substantially lower than the pay for comparable positions in health care, education and other non-profit organizations.

While this may be true, there is no shortage of interest in the top jobs at private human service agencies in Massachusetts.

A recent search for an executive director at the Association for Community Living — a large Springfield human service agency with lucrative state contracts — netted 125 applicants.

William Wolk and Henry Cheney are busy men.

According to an unreleased draft audit by state Auditor Joseph DeLuca, together they make the day-to-day decisions for four non-profit corporations.

Officially, Wolk is the president of Quincy-based Work Inc. and Cheney is the executive vice president. The two also serve as consultants to several corporations with strong ties to Work Inc.

In reality, alleges DeLuca, Turn to Page 20

Non-profits soak up sun & funds with Fla. property

By DAVID ARMSTRONG

The Buenaventura Lakes development in Kissimmee, Fla., is graced by a golf course and a lake, and is only 15 minutes from Sea World and Disney World, two of the world's big best tourist attractions.

At 320 Plumwood Circle in the development sits a three-bedroom home purchased new in 1986 by a subsidiary of the non-profit Greater Lynn Mental Health and Retardation Association Inc.

The \$105,000 condominium faces a nearby lake and features a pool surrounded by a large patio and a colorful garden. The entire area is screened in to protect satelites from bugs.

The association, which provides group housing for the mentally retarded and other services, relies heavily on state contracts to survive.

In fiscal 1990, for instance, the \$107 million in state human service contracts awarded to Greater Lynn accounted for 89 percent of the agency's total revenue.

Why does a non-profit human service provider, funded almost entirely with taxpayer dollars, own a Florida condominium?

Albert Bieau, the 1991-92 executive director of the Lynn-based agency, said the Florida purchase was a cost-efficient way for clients to visit Disney World.

"Basically, we use it for our retarded and mentally ill citizens to vacation," Bieau said in an interview.

He said the unit is also used as a benefit for employees.

A Herald examination of the property, however, revealed that clients of Greater Lynn rarely use the home.

Year round neighbors of the Greater Lynn property could only recall one instance in which they observed a disabled or retarded visitor at the home. Others said they could recall no visits.

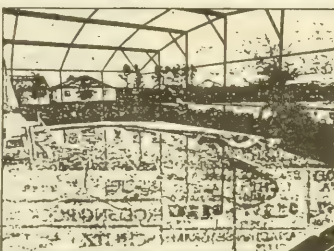
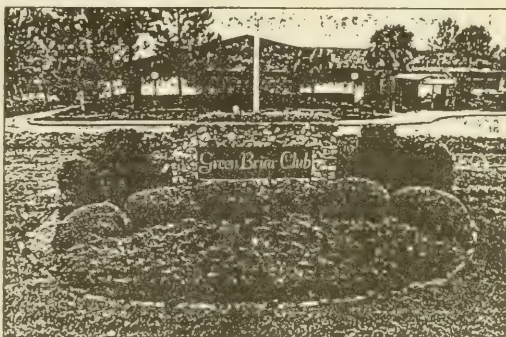
"I can't say I have," neighbor Joan Grant replied when asked if she ever saw retarded or disabled persons at the condominium directly adjacent to her home.

Grant, who has lived at 228 Plumwood Circle for two years, said the condominium is known to neighbors as a vacation rental property.

When pressed for the specific number of visits agency clients made to the Florida property by last year, Bieau acknowledged they stayed there only twice.

The house was occupied by employees and renters or unused during the balance of the year, he said.

Because he has been unable to give substantive rates to employees, Bieau said the Flor-



NON-PROFIT: Purchases of Florida properties by non-profit health care agencies contracted by the state are being questioned. The purchase of an Orlando condominium unit, above, bought by New England Residential Services Inc. of Rhode Island is under scrutiny by the state. Greater Lynn Mental Health and Retardation Association Inc. admits disabled people have vacationed only twice in its Kissimmee home with pool top left. The Vesting Nurse Associates Inc. of Dedham also owns a condominium unit in Kissimmee, bottom left.

New England Residential Services Inc., a Rhode Island-based human service provider totally dependent on \$7.3 million in Massachusetts contracts, said it purchased the unit with the goal of starting a program for the mentally retarded in Florida.

A program was never started, however.

"It was basically a waste," admitted David Ruppel, the president of NERS.

Ruppel said he and other NERS officials used the Florida condominium "a couple times" while "looking around and talking to people" about starting a program in the state.

In 1991, NERS sold the condominium at a \$5,000 loss to a Newport, R.I. acquaintance of NERS Vice President Michael Worthen, also of Newport, R.I. Ruppel said the company decided against putting the property on the real estate market to avoid paying a realtor commission.

DMR Commissioner Campbell said he is investigating the possibility state money was used to purchase the unit.

A third provider — a subsidiary of the Vesting Nurse Associates Inc. of Dedham — also owns a condominium in Kissimmee.

The non-profit group said the condominium is used only by employees, at no cost, and is a valuable recruitment tool.

ida home serves as a valuable and legitimate employee benefit. He said the Florida property pays for itself because of the renters.

While allegedly self-sufficient, the Florida property was purchased at a bad time for Greater Lynn.

The non-profit agency was running a deficit and was being criticized internally by state officials for seeking unreasonable rent amounts for some programs.

However, state officials did nothing to block the purchase. DMR Commissioner Philip Campbell said the condo purchase was not a concern because DMR funds were not involved.

However, other state agencies have stepped in and ordered vendors to sell vacation properties — purchased without direct state funding — based on concerns such purchases drain resources affecting the overall quality of services.

In neighboring Orlando, only a quarter-mile from Sea World, another large Massachusetts human service contractor purchased a condominium under questionable circumstances in 1990.

300 for [unclear]

2-18-93

P.1

State fails to drop shady firms

Third of five parts

By DAVID ARMSTRONG

In June of 1991, a 160-page report landed with a thud on the desks of top officials at the state Executive Office of Health and Human Services.

Several years in the making, the report contained page after page of allegations against a number of private human service providers doing business with the state — including charges that money earmarked for needy clients was be-

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PUBLIC SERVICES



Corrupt vendors allegedly

PUBLIC SERVICES



PRIVATE GAIN

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ing squandered and misapplied.

This report reveals a myriad of highly questionable activities, including skimming funds from human service contracts," wrote the state human service investigators who prepared the report.

The report alleged that money allocated for food, clothing and personnel had been misused; that companies had employed illegal billing practices, misused client funds, diverted funds via wire transfers, established sham corporations and engaged in questionable real estate practices.

So grave was the situation that the report urged top state officials to terminate millions of dollars in contracts with four of the corporations and permanently bar many of the individuals running them from obtaining any future state contracts.

Today, however, all but one of the companies continues to do business with the state. One contract was terminated, but only because the company filed for bankruptcy, not because of the findings of the June 1991 investigative report.

Many of the individuals in the report, who allegedly neglected the needs of clients in order to enrich themselves, also continue to do business with the state.

The Herald obtained a copy of the report from a source after the state refused to release it.

"The report you seek is not a public record," wrote Stuart Kaufman, the general counsel for Health and Human Services. "The factual report is incomplete and the policy positions relating to its formulation in the draft report remain under development."

However, sources familiar with the preparation of the report said the June 1991 document is the final version.

A high-ranking state official familiar with the report claimed the document is filled with "a lot of crap."

"The official, at the same time, conceded that a number of very troublesome facts" are contained in it.

While Massachusetts officials are busy skimming the release of the report, others are taking action.

The Ohio attorney general indicted one of the principals in the Massachusetts report, Charles Virga of Duxbury, for allegedly skimming \$1.7 million from contracts to house the mentally retarded in that state.

Federal law enforcement authorities, meanwhile, are reviewing the Massachusetts report as part of a multi-state investigation of many of the same agencies, sources said.

The failure of the state to act on the report may be surprising, but it is not unusual.

A four-month investigation by the Herald has found that private human service contractors frequently abuse the state system, which is vulnerable because of inadequate oversight and lax enforcement.

In addition, Massachusetts rarely takes action against private vendors now delivering \$1.3 billion in human services for the state.

"For the most part, there are plenty of rules for vendors and the system is generally working," said Bruce Stasdel, a former state auditing official. "What we need is more effective enforcement in those few cases where action is justified."

□□□

Hidden on a quiet side road off busy Court Street in downtown Plymouth is a nondescript brick storefront housing the offices of Habituation Assistance Corporation Inc.

The for-profit company, run by Alan Eddy of Duxbury, is one of the agencies highlighted in the unreleased state investigative report.

Habituation, which provides day programs for the mentally retarded, received \$48,000 from contracts with the state Department of Mental Retardation last year.

There were no other bidders for the work performed by Habituation, according to the DMR.

Eddy is a longtime friend and business partner of Virga, the man indicted in Ohio and barred by a Superior Court order from doing business in Massachusetts. In fact, Eddy was the paid treasurer of the Ohio corporation used by Virga to allegedly pocket \$1.7 million in funds earmarked for the mentally retarded, according to an Ohio legislative report.

The Ohio corporation — Community Assistance Corporation — also operated programs in other states, according to records.

In fact, CAC contracts were terminated by authorities in Maryland, the District of Columbia, Louisiana and Florida, records reveal.

Eddy was also a principal in Human Services Resource Center Inc., a Cape Cod company run by Virga.

The company operated group homes for the mentally retarded that were cited for poor client care, including inadequate food supplies and misuse of client funds.

The miserable conditions at the group homes and the company's severe financial problems led to the 1990 court order banning Virga from operating health service agencies.

Eddy, however, was unaffected by the court ruling.

While Virga is prohibited from running his own business in Massachusetts, his old friend Eddy has

been there to help out.

He hired Virga as a consultant and placed Virga's wife on the Habituation payroll after the court ruling.

The state report, meanwhile, highlights a number of Eddy's own problems at Habituation, including:

• Habituation allegedly paid health insurance benefits in 1989 for individuals who were not employees of the corporation, including Virga.

• Former employees alleged that Habituation routinely bounced payroll checks and that employees were asked to misrepresent their titles, skills and the agency's operations during state and federal inspections. Eddy said he has never bounced a check.

• An audit of the company's fiscal 1986 books found "several deficiencies in internal controls, unusual business practices and undocumented costs."

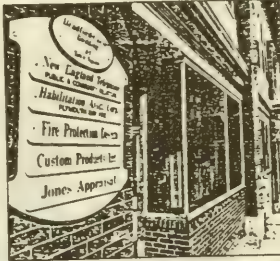
In an interview, Eddy acknowledged problems with companies he operated with Virga, but said any shortcomings resulted from poor business acumen rather than deliberate wrongdoing.

"I don't believe anybody ever did anything inappropriate with any funds in any of the operations," he said.

Eddy also said he concentrates solely on operating his Plymouth company now, and that state reviews of his performance have been extremely positive.

DMR Commissioner Philip Campbell said the department is satisfied with the performance of Habituation.

Campbell, who was appointed



UNTOUCHED: Despite scathing criticism in an unreleased 1991 state report, top right, and a recommendation that its contracts be terminated, Habituation Assistance Corp. of Plymouth above continues to provide day programs for the mentally retarded.

to his position in July 1991, also said he was unaware of the June 1991 report recommending the state terminate all contracts with Habituation.

"I know there have been allegations made," Campbell said. But he added, "I have seen no reports concluding we shouldn't do business with them."

A simple Xerox machine led to the downfall of Southeastern Regional Vendor Educational and Support Services Inc.

State auditors, conducting a routine audit in 1987, noticed the state was billed for a different

INVESTIGATIVE REPORT 01-623-89

June 1991

An Investigative Report by the Executive Office of Health and Human Services

Commonwealth of Massachusetts
Executive Office of Health & Human Services
One Ashburton Place
Boston, Massachusetts 02108
(617) 727-7600



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type of Xerox copy than that actually purchased by SERVSS.

Puzzled by the discrepancy, the auditors looked in greater detail at the company, which operated state-funded group homes for the mentally retarded in southern Massachusetts.

Five years later, the company's two founders and an associate stood in a federal court dock and pleaded guilty to defrauding the state of \$1 million in contract money for programs for the mentally retarded.

Tenager dollars targeted for the retarded were actually used to purchase a condominium in Florida, lease numerous cars, including a Volvo and a Mercedes, and used to pay for personal expenses.

The men — Stephen Williams, Bruce Kotch and Robert Alexander — are currently awaiting sentencing.

SERVSS disappeared in 1989. With the filing of corporate name-change papers, SERVSS became Integrated Services Associates Inc., a Nonion-based company now doing \$4 million a year in business with the state.

Other than the name change, however, the corporation that was called SERVSS remained intact.

In fact, the newly named company Integrated Services is being paid by the state based on a 1980

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From Page 14

contract award to SERVESS. DMR officials said Integrated Services will not have to bid again on the state work until fiscal 1995.

The head of Integrated Service is William Polis, the same man who headed SERVESS during the period in which the state was bailed out of \$1 million, records indicate.

Polis now earns \$85,000 a year as the director of the renamed SERVESS, a \$28,000-a-year jump since the company changed names, according to financial filings.

At the same time, in its most recent financial filing, Integrated Service reports a \$56,860 deficit for

fiscal 1991.

While Polis was not indicted in the scheme, Assistant U.S. Attorney Michael Loucks said he described Polis during a court hearing as a "puppet" of the three men who actually did the stealing.

Loucks said Polis was appointed executive director of SERVESS in 1984 at the direction of Kotek and Williams, who started the company.

Polis' first act as executive director was to grant a lucrative management services contract to a company operated by Kotek and Williams, Loucks said.

The management company was the vehicle used to swindle the state out of funds earmarked for the retarded, according to the

PUBLIC SERVICES PRIVATE GAIN

federal indictment.

Loucks said that for 2½ years after Polis was appointed executive director, Kotek and Williams controlled Polis as well as the operation of SERVESS.

"They had control over Polis," he said. "They would tell him to execute a lease and he would do it."

The June 1991 state report alleged the management contracts signed by Polis cost the state "millions of dollars since 1985 without making significant contributions to the operations of programs."

The report recommends terminating all contracts with Integrated Service.

In an interview, Polis conceded he followed the orders of the management company for several years, but said his agency is now solely operated by an internal management team.

Despite the fact Polis agreed to the management contracts and was at the helm of SERVESS while state contract funds were illegally siphoned off by the three other men, the state said it has no plans to stop doing business with Polis.

DMR Commissioner Campbell said it was his understanding "the leadership of the organization has substantially changed."

But the state investigators who urged an end to business with Integrated Service said the only real change was a new name and the end of the management company.

□□□

By 1989, the former SERVESS had grown so large it had "virtually cornered the market on residential contracts for mentally retarded clients" in the southeastern

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let vendors misuse millions\$

region of the state, investigators said.

This kind of monopolistic growth is one of the major problems facing state officials forced to contemplate the termination of business with a troubled private vendor.

The dilemma is this: Who will take care of the clients left without services by an agency shut down by the state?

"In some areas there is not a whole lot of competing vendors to start with," said Health and Human Services legal counsel Kaufman. "Agencies sometimes fear there will be no one else out there to provide services."

After years of privatizing human services and cutting its own programs, the state is often unable to absorb clients set adrift by bad vendors back into the state system.

At the state Department of Mental Retardation, for instance, private contractors now provide services to 84 percent of the agency's clients.

There are other pressures on state agencies to continue doing business with abusive vendors.

Kaufman said pressure from

corrupt private vendors will continue to outsmart the state with a deliberate strategy of taking the clients no one else wants.

"These clients many times are almost hostages," said the investigator, who asked not to be identified. "Some agencies willingly take the worst clients so no matter how outrageous their conduct is, the state doesn't want the clients back."

"It's a shame."
Tomorrow: The story of one persistently troubled vendor highlights nearly all of the problems with the state's current system of privatization.



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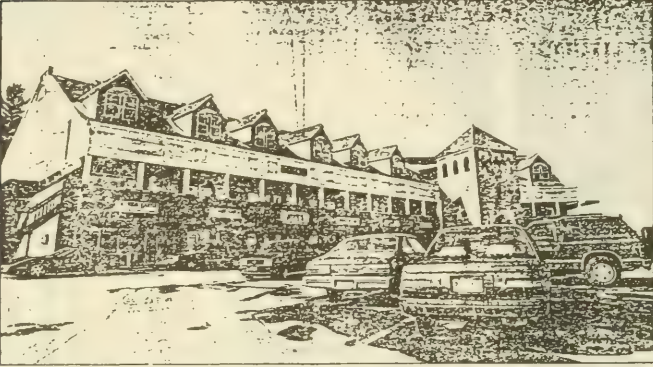
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SERVESS UNINTERRUPTED: Integrated Service Associates Inc. of Noron, above, continues to do \$4 million in business with the state after changing its name from Southeastern Regional Vendor Educational and Support Services Inc. in 1989. SERVESS' two founders and an associate are awaiting sentencing after pleading guilty to swindling the state of \$1 million.

and Support Services Inc. in 1989. SERVESS' two founders and an associate are awaiting sentencing after pleading guilty to swindling the state of \$1 million.

Staff photo by Michael Lian

Response to probe: Circle the wagons

By DAVID ARMSTRONG

On Dec. 18, top staff from several private human service agencies and the state officials who award them lucrative contracts met to discuss some important business.

One of the primary agenda items: How to anticipate criticisms and jointly respond to complaints about the privatization of human services by state government.

The meeting, while judged by one organizer to be "inappropriate," was not unusual. Privately and the state officials paid to oversee them frequently worked hand-in-hand to monitor the efforts of the Herald during a four-month investigation of the \$1.2 billion in contracts awarded by the state to private human service agencies every year.

And despite the fact that the state's network of private human service vendors is riddled with waste, fraud and abuse, state officials spent time and effort writing confidential memos in which they sarcastically displayed problems with private vendors, inquired about blocking the release of public records and voiced concerns about the potential damage to Weld administration privatization plans.

Perhaps more troubling are efforts by state officials — charged with ensuring that taxpayer monies are spent appropriately — to warn the private agencies they are supposed to regulate about requests from the Herald for public records.

"I was told two months ago the Herald was doing a negative report," Alan Eddy, the president of Rehabilitation Assistance Corp., said last week. "We had a couple of phone calls from (state DMR) people asking me the same questions you are asking. They told me they are gearing up for a negative article."

The state Division of Purchased Services, the agency responsible for monitoring the financial returns and contracts of some 1,600 human service vendors, also notified many agencies of the Herald's public record requests — despite the fact that the division frequently complains of being understaffed and overwhelmed by vendor paperwork.

On the vendor side, an organization funded by state-supported private mental health agencies — Mental Health Corporations of Massachusetts Inc. — hired a public relations firm, in part, to investigate the activities of a Herald reporter.

The firm, Zoulas Communications, went so far as to make a formal public records request of the attorney general's public

Turn to Page 24

Clergyman's track record one of the worst

The Rev. Charles Virga of the Trinity Episcopal Church in Marshfield is admired by his flock and recently received a lengthy contract extension from a grateful church vestry.

To others, however, Virga is better known as one of the worst providers of human services in recent Massachusetts history.

His conversion to the priesthood completed in 1981, has disgusted investigators in several states where Virga operated publicly funded programs for the mentally retarded.

"I couldn't believe it when I saw him in a collar," said one investigator who asked not to be named.

As a result of his escapades, Virga is banned by court order from operating health-related businesses in Massachusetts and pleaded no contest in Ohio last year to corruption charges stemming from his operation of group homes in that state.

He was also the target of a lengthy state investigation in Massachusetts that uncovered a significant pattern of allegedly shoddy and dangerous client care and financial abuses.

Despite this record, Virga was ordained an Episcopal priest in Michigan and assigned last year as the priest-in-charge of a small parish in

Marshfield

The assignment was convenient for Virga.

He has lived for most of his adult life in Duxbury, the South Shore town next door to his new parish.

Virga has been at the parish for a year, and the church recently granted him a contract extension through July 1994.

A recent evaluation by parishioners of Virga's performance was overwhelmingly positive.

"Rev. Virga has brought love, sensitivity, caring and joy to our parish," read one of 96 responses.

Church members concerned with Virga's hiring and his history of operating private human service agencies, however, have been ostracized by the congregation, some members say.

In fact, Bishop Barbara Harris, a top official of the Massachusetts diocese, responded to questions about Virga's hiring and past with a plea for "patience and tolerance," according to a letter.

She refused to return several telephone calls from the Herald. Virga declined to comment.

Virga's conversion to the priesthood followed the collapse of his \$2 million nationwide human service network.

A state report on Virga's activities claimed his first experience in operating a hu-



REV. CHARLES VIRGA
Banned from human services field, man service vendor was typical of all his dealings.

The report alleged he operated a western Massachusetts company called Browndale Inc., leaving the company in the late 1970s in "serious fiscal and programmatic difficulty."

Virga then took over the operation of Communities for People Inc., according to the report, leaving the company in "fiscal chaos." The agency was eventually defuncted.

As Virga developed his empire, he allegedly recruited and lured key former state officials.

He brought in former Administration and Finance Secretary John Buckley to run a Duxbury-based compa-

ny that managed several of Virga's human service operations, records indicate.

Another principal in this Duxbury company — called Saug Harbor Support Services Inc. — was Robert Alexander, who pled guilty last year to participating in a scheme to steal \$1 million in state money earmarked for the mentally retarded.

Investigators also said they discovered the names of several former high-ranking state government officials on travel records maintained by Virga agencies.

It was in Ohio where Virga encountered his most serious problems.

He pleaded no contest last June to 11 counts of theft and deception in a scheme to bill taxpayers of \$1.7 million in contracts for the mentally retarded.

He was also accused of operating dismally substandard group homes for the mentally retarded.

"Two of the houses were condemned," said Kathleen Barch, an investigator for the Ohio attorney general. "We have pictures. It will turn your stomach."

In July, Virga changed his mind and asked a judge if he could reverse his plea and go to trial on the contracts. A decision on that request is expected soon.

— DAVID ARMSTRONG

Service providers, officials close ranks in face of probe

From Page 15

charities division for copies of all Herald requests for information from the office, sources said.

It was in this atmosphere that private agency officials traveled in December to a state

office building to meet with bureaucrats at the Division of Purchased Services.

"There was a feeling we or they were being investigated," John McManus said of the meeting to develop a joint response to privatization criticism.

McManus is the executive director of the Massachusetts Council of Human Service Providers Inc., an organization of vendors who arranged the meeting.

"It was not a very wise thing to put on (the agenda)," said McManus, who did not attend the meeting. "These meetings are supposed to be technical in nature."

It is unclear what kinds of strategies were discussed at this meeting, but confidential memos from the Division of Purchased Services hint at possible scenarios.

One unsigned memo urges recipients to anticipate the key arguments about privatization, and predicts these arguments will be "expressed in the most simplistic manner."

PUBLIC SERVICES



The memo warns one potential argument is, "Look at these blatant abuses! Salaries are too high and too low, people have expensive cars, petting zoos, etc."

While the memo sarcastically outlines many of the perceived problems with privatization,

zation, it offers no rebuttal. In other memos, Deputy Purchasing Agent Dana Roszkiewicz, who oversees the private human service provider system, voices concerns about public records requests and potential attacks on his boss, Administration and Finance Secretary Peter Nessen.

In a memo to Nessen's press secretary, Roszkiewicz voices concern about a Herald request for his agency's computer database of publicly available vendor financial filings.

"To what extent are we obligated to share, wholesale, data systems containing extracted information from public documents?" he says. "I am afraid of possible misuse or distortions of fact here."

The Herald later obtained the database.

In another memo, he warns his boss, "(the Herald) may be preparing to engage in some degree of Nessen bashing."

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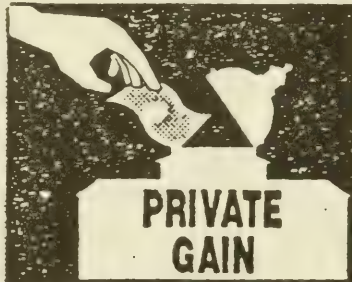
Political ties is name of the game

Fourth of five parts

By DAVID ARMSTRONG

The event at the Crystal Springs School in Assonet on March 18, 1991 was billed as a "Saint Patrick's Luau"

PUBLIC SERVICES



for Attorney General L. Scott Harshbarger.

In reality, the event was a \$125-per-person campaign fund-raiser on the lavish grounds of

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Political influence pays off

PUBLIC SERVICES



From Page 1

the school — and another in a long series of shrewd political moves by Crystal Springs President Charlie Young.

The event, held at the school's indoor pool, was just one of many Young has arranged for Harshbarger. In all, Young has been responsible for helping to raise thousands of dollars for the state's top law enforcement official.

Young also has suggested that employees of his school volunteer their time on behalf of politicians the school supports. At Young's direction, the school appears to have violated federal tax regulations prohibiting political activity by non-profit, tax exempt corporations.

And yet Harshbarger is just one of many Bay State politicians benefiting from Young's efforts.

U.S. Rep. Barney Frank (D-Newton), House Majority Whip J. Edgar Hoover (D-Somerset), the new chairman of the Democratic State Committee, and well-connected state Rep. Robert Correia (D-Fall River) are among the other politicians who have benefited from Young's largesse.

Young, 36, doesn't hold fundraisers merely for the pleasure of rubbing elbows with some of the state's most powerful officials.

Slapping politicians' backs and filling their campaign coffers is a key strategy used by Young to protect his treasured \$4.1 million facility for mentally retarded children, which is funded almost entirely by taxpayer dollars.

And for Young, a man with a checked past and no prior experience in the field of mental retardation (see related story, Page 13), there is plenty to protect.

He draws \$107,000 in salary a year and drives a \$41,500 Mercedes station wagon leased by the school. His wife, the school's financial director, is paid at least \$14,387 a year.

In Falmouth, the school owns a \$227,000 vacation home only steps from Surf Road, featuring dramatic views of Vineyard Sound from a second-floor deck.

Until last month, Crystal Springs owned a second home in Falmouth less than a mile from the first.

Located on scores of acres

adjacent to the Assonet River just north of Fall River, the main school facility is flush with other perks.

Tanning tables, an indoor pool, a private petting zoo stocked with exotic animals and a specially created camping area are among the luxuries Young has added to the facility.

At the same time, Crystal Springs has consistently lost money during the past several years, incurring a net loss of \$402,000 in 1991, according to school records.

Audits and other financial reviews of the facility have raised serious questions about the school's operations and Young's fitness to operate a multimillion-dollar company.

Yet state officials have repeatedly worked to rescue the non-profit school and are currently trying to prop Young up by finding state agencies to lease empty buildings from him.

And some of the politicians who have benefited from Young's many efforts on their behalf have come through with intensive lobbying efforts to keep the school afloat.

With its troubling themes of high salaries, plush perks, financial abuse, a friendly board of directors, lax enforcement and political influence, the story of Charlie Young and Crystal Springs exemplifies much of what is wrong with the



CHARLIE YOUNG
Friends in high places

state's rapidly growing \$1.3 billion-a-year private human service provider system.

And no one appears to have the answer to the obvious question: Why is Charlie Young still in business and receiving millions of taxpayer dollars every year?

"It would be a great statement to say, 'Hey, this just isn't going to be put up with,'" said state Administration and Finance Secretary Peter Neenan, who advocates cutting state funding to the school.

"No one can give me a right reason not to go and be definitive about closing (Crystal Springs),"

Nevertheless, Crystal Springs lives on.

□□□

While parents of Crystal

Spring students say Young has dramatically improved conditions at the school since taking over the facility in 1981, records obtained by the Herald reflect a lengthy and striking history of financial misuses and ethical problems.

Although Gov. William F. Weld's drive towards privatizing public services is aimed at promoting greater efficiency and reducing costs, Crystal Springs — an example of privatization — is tangled in a net of constant debt and yearly deficits, even as it spends thousands of dollars on expensive perks.

Recently, Young has operated the school with little outside interference or oversight.

The school's board of directors — although charged by law with acting as a fiscal watchdog for the school and its clients — has allowed Young to operate virtually unchecked. And some members have even engaged in questionable transactions with the school that raise the specter of conflict of interest.

In one case, the school purchased an Assonet home owned by advisory board member Robert Viana in 1989 for \$224,000 — an amount \$15,000 higher than the "reduced price" advertised in a local newspaper eight months earlier.

Young defended the charity's decision to pay the higher price by pointing to improvements Viana made to the house after the sale.

Records obtained by the Herald reveal a number of other questionable activities and expenditures at the facility.

● A 1990 state memo indicated that the school owned six luxury automobiles designated for the personal use of five employees who were also board members. Among the cars were a Volvo, a Lincoln Town Car, two Mazda sports cars, a Jeep wagon and the Mercedes.

● A Sept. 14, 1992 memo warned of "major staffing deficiencies, especially among clinical professionals" at the school.

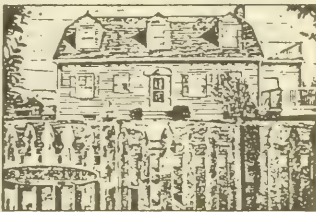
● The purchase of an \$8,500 Datsun for a petting zoo at the school.

● The purchase of two expensive Falmouth vacation homes in 1983.

● An alleged \$378,000 overbilling by the school of the city and towns sending students to the facility from 1986-1991.

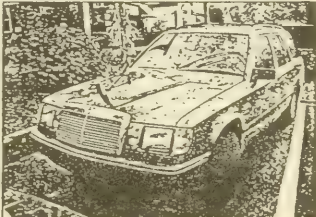
● The improper use of client trust fund money to cover payroll at the school. Young admitted that he used the trust fund money, but insisted he paid it back. The state alleged Young owed \$33,777 to client trust funds as of Jan. 21, 1991.

● A critical 1984 audit detailed numerous financial problems at the facility and a lack of financial controls. The auditors said the school also bought



GETAWAY: Crystal Springs School owns this \$227,000 vacation home near the ocean in Falmouth.

Staff photo by Peter O'Connell



HIGH STYLE: A Mercedes driven by Crystal Springs President Charlie Young is parked at the school in Assonet.

Staff photo by Peter O'Connell

CRYSTAL SPRINGS SCHOOL PERKS

Executive automobile costs	\$30,595
Petting zoo animals	22,000
Cape Cod vacation homes	\$4,000
Day care expenses	\$100
Cost of buildings owned, but not used by school	\$227,000
Total cost per year	\$184,795

COSTLY: These are some of the annual expenses at Crystal Springs.

real estate with grant money targeted for speech, behavior and learning programs for children at the school.

● The school employs as a grant writer Owen Kagan Jr., former chairman of the Fall River Housing Authority who served nine months in a federal prison in 1982 after being convicted of conspiracy to commit bribery, according to federal records.

Despite this steady stream of documented problems, state funds continue to flow into the school.

"If the state had any courage, they would have taken care of this," said a former state human services official who advocated cutting funds to the school.

□□□

But Rep. Menard, the chair-

man of the state Democratic Party, doesn't see it that way.

Like several other politicians, Menard has been there for Young when he has needed help on Beacon Hill.

In combination with powerful ex-state Sen. William "Bert" MacLean (D-Falmouth), Menard lobbied hard for Crystal Springs last year as the school teetered on the brink of financial collapse.

The two legislators were successful in winning a moratorium preventing the state Department of Mental Retardation from moving students out of the school.

The school receives \$97,706 to \$113,063 a year for each student.

The lawmakers also ar-

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Friends in high places help

From Page 12

ranged meetings between Young and state officials to iron out disputes.

In several instances, state officials highlighted the interest of the two lawmakers and state Rep. Robert Correia in memos discussing the Crystal Springs case.

"I did this because (Young) asked me to," Menard said in an interview. "I would do it for any constituent."

But Young doesn't live in Menard's district — and the school is also located outside the district.

"That's true," Menard said when informed neither Young nor the school was in her district. "If I know someone and he is not a constituent, I certainly

give them access."

This kind of access clearly energizes Young.

He has helped organize volunteers and fund-raisers for many candidates, including Menard.

In addition, Menard said Young donated more than \$500 in printing services to her campaign. Sources said the school has a sophisticated printing shop staffed by a full-time employee.

As a tax-exempt, non-profit organization, Crystal Springs is precluded from engaging in any political campaign on behalf of or in opposition to any candidate, according to Internal Revenue Service regulations.

Violation of this rule can lead to the loss of tax-exempt

PUBLIC SERVICES



status.

Another local politician told the Herald that Crystal Springs performed printing work at no cost for her campaign. The politician said the school also did printing work for several municipal candidates.

When asked if the school was performing free printing jobs for political candidates Young said the school charges politicians to use its printing presses.

After initially agreeing to supply the Herald with copies of bills for printing work for politicians, a lawyer for Young later said the school would not provide those documents.

Menard said she reported the printing work as an in-kind contribution and has no idea who actually paid for the printing.

□□□

The powerful Menard is not the only politician to benefit from the work of Young and Crystal Springs.

This past fall, Crystal Springs properties were littered with signs supporting John Quinn, a successful candidate for state representative.

School employees have also been asked to work for candidates supported by Young.

In a memo to school department heads in 1990, Young solicited their help in passing out leaflets and holding signs for certain political candidates.

"More than ever before, the human service field needs the

CRYSTAL SPRINGS JEWELRY

7

AT HOME

State ignores evidence, helps school carry on

By DAVID ARMSTRONG

In March 1991, the state Division of Purchased Services issued a scathing report on the management of the Crystal Springs School in Asonnet.

"We believe that since 1987 there have been numerous errors of judgment and sound management decisions at (Crystal Springs)," the report stated.

The report cited the decision to build a rehabilitation center with state funds approved for hiring direct-care staff; the development of a petting zoo; the purchase of luxury automobiles for executives; and the payment of high salaries to top school officials as examples of problems at the facility.

Since the release of the report, however, the state has not taken action against the trou-

bled school, but worked instead to bail it out:

● In June 1992, the Department of Mental Retardation made an unnecessary \$150,000 payment to the school. The DMR said it was making the payment even though it did "not have a contractual obligation" to do so because the maximum funds approved for the school had already been spent.

● The state Executive Office of Human Services has made efforts to find agencies willing to lease empty space from the school.

● A moratorium was imposed last year by the Executive Office of Health and Human Services prohibiting the DMR from taking clients out of the school and moving them to other facilities.

The moratorium has now ex-

pired, and DMR is removing some clients.

The state has even failed to follow its own directives for correcting problems at the school.

A corrective action plan agreed to in 1991 called for Dana Roszkiewicz, the director of the Division of Purchased Services, to seek an opinion from the attorney general by the end of the year regarding alleged overbillings by Crystal Springs.

Roszkiewicz, however, failed to seek the opinion until asked about it by the Herald in December — a year late.

In a statement, Roszkiewicz said there was no practical impact resulting from his delay. He said the school had previously acknowledged responsibility for legitimate overpayments.

The school tells a different

story, however.

"(Crystal Springs) vigorously denies the overpayment issues," the school's consultant, Margaret Keenan, wrote to state officials on Nov. 23, 1992.

And in an interview last month, Charlie Young also denied that the school owed money to any city or town. In fact, he said the school was owed money.

Young also defended many of the items identified as wasteful perks by the state.

He said an expensive petting zoo is used as a therapeutic tool for children at the school. He also said the Cape Cod vacation homes purchased by the school were occasionally used by children.

In addition, he said direct state dollars were not used for those purchases.

Young is also backed by a strong association of parents whose children attend the school. This support has played a role in the reluctance of state officials to take the school on, several sources said.

In fact, the Herald was been deluged with calls from parents of some of the 100 students at the school who said they were pleased with Young's performance.

The parents group told state officials it was "absolutely unpersuaded that the school's problems can be traced to mismanagement."

The parents have also expressed strong support for dedicated staff at the facility. Some of those same staff members, however, have privately complained to the Herald about Young's management.

Herald p.14- 2-19-93

Irregularities alleged in previous Young venture as contractor with state

By DAVID ARMSTRONG

The recent problems and questionable activities at the Crystal Springs School should come as no surprise to state officials overseeing the millions of dollars the school receives from the state each year.

School owner Charlie Young, a former restaurant owner and chemical-cleaning salesman, ran into trouble almost immediately after he began contracting with the state.

Young landed his first state contract in 1980 at the Walter E. Fernald School for the mentally retarded in Waltham.

The contract called for Minutemen and Women Contract Cleaners Inc., a company organized under the name of Young's former wife, to clean several buildings at the school.

Less than a year into the contract, however, the state Department of Mental Retardation terminated the agreement.

A DMR official wrote to Marianne Young Jan. 28, 1981, and said an audit of the contract "uncovered certain questionable items in the billing of your current cleaning services contract."

The audit by Zafarana, MacDonald & Savy alleged the Youngs overbilled the state \$41,510 during the brief contract period. The auditors also found serious discrepancies in the company's invoices, including differences in check amounts and numbers.

The audit reported that an investigation of the bid process by Fernald security staff determined Minutemen had included the resumes of personnel who did not work for the company as part of its proposal.

In addition, two of the three other businesses bidding on the cleaning contract "were ficti-

tious agencies," according to the auditor's report.

The Youngs denied all of the allegations in the audit, blaming disgruntled employees and poor contracting procedures for the charges.

The audit also sparked allegations that a Fernald employee unsuccessfully solicited a bribe from Young.

The case went to trial, but the employee was found innocent when an auditor testified Young told him a different employee solicited the bribe, a source familiar with the case said.

Young, in an interview last month, said the bribery case was "one person's word against another," adding he didn't remember the specifics of the case.

Also included in the audit is a document prepared by Minutemen highlighting the educational and work experience of Young.

The document indicated Young had a "bachelor's degree in business administration and marketing."

He has no college degree.

Young said he had no explanation for the false claim in the Minutemen documents, but volunteered he did complete three years of "MBA work" at the University of New Hampshire.

The university, however, said it has no record of Young ever attending the school.

The Minutemen experience didn't dampen Young's enthusiasm for state contracting and the world of human services.

Instead, Young started over, moving his family to the southeastern corner of the state and searching out new opportunities away from Fernald.

In 1981 he landed at Crystal Springs.

Santa Fe Herald 2-20-93

All agree on need for privatization reforms

Last of five parts

By DAVID ARMSTRONG

The scorching heat inside a Suffolk University auditorium last November had nothing to do with the furnace — and everything to do with a nasty debate about privatizing hu-

PUBLIC SERVICES PRIVATE GAIN

man services.

Representatives of state employee unions

Turn to Page 6

Debate over privatization

PUBLIC SERVICES



From Page 1

and local academicians had spent the better part of two hours bashing Gov. William F. Weld's privatization plans before one of the governor's top aides decided he had heard enough.

"I hope that no matter what happens over the course of the next few years people try to keep the conversations on what matters — which is the issues — and stay out of the bullshit, frankly," said Charles Baker, the secretary of the Executive Office of Health and Human Services.

Critics of privatization efforts were delighted by Baker's eruption, relishing their ability to get under the skin of a high-ranking Weld administration official.

Baker, on the other hand, remains disturbed by the outburst and has privately complained about the personal and sarcastic attacks made on Weld that day.

Baker's unusual public display of anger highlights the often emotional and personal nature of the debate about how the state should care for its neediest residents.

As the Weld administration pushes for further privatization of human services, it finds itself confronting angry state employee unions, legislators and researchers opposed to its efforts.

Though it takes many forms, the battle centers on a single, simple question: Is privatization working?

The answer is complex — it appears to be both yes and no. Clearly, some of the Weld initiatives have had elements of success — particularly the closing of some public health hospitals.

And even some of the barest critics of Weld's plans to further privatize human services concede private agencies are often capable of providing better services than state facilities.

On the other hand, some of the administration's efforts have been deeply troubled.

While the report card on the privatization of human services is mixed, both sides agree the current system requires serious reforms to eliminate fraud and waste and tighten financial controls on vendors.

In fact, state officials readily admit they need to do more



SUCCESS: State Secretary of Health and Human Services Charles D. Baker, left, and Philip Campbell, commissioner of the Department of Mental Retardation, lock up the Belchertown State School in December. The closing of the facility has been widely regarded as successful. (The Globe)

to ensure taxpayer dollars are spent appropriately, but insist the contracting of human services is generally working to the government's advantage.

The system ain't perfect, but it is working better than we give it credit for," said Baker.

Baker has created an in-house task force to examine how the state purchases human services. He is expected to propose a number of reforms.

With more than a billion dollars at stake, experts outside government warn Baker that the state had better act, and act quickly.

"This is where the money is," said Lawrence Overlin, a conservative researcher. "It is a budget buster."

□□□

Allan Smith's refusal to eat for 45 days was a terrifying protest of the Weld administration's plan to shut down nine state human service facilities.

The 70-year-old Smith, who suffers from Lou Gehrig's disease, launched his hunger strike in an unsuccessful attempt to block the shutdown of the Lakeville Hospital, a state Department of Public Health facility.

Pictures of the emaciated Smith on the nightly newscasts last year were hardly the kind of public relations the state had hoped for when it announced its plan to close these facilities.

One year later, Smith's wife said her husband is displeased with his new home at a private rehabilitation center in New Bedford.

"He is definitely dissatisfied," said Nancy Smith. "The nursing staff is very good, just like Lakeville. But other than

that he is not pleased." Mrs. Smith said the New Bedford facility has small rooms, poor television reception and a lack of outdoor activities for the ill residents.

A study by the University of



CHARLES BAKER

Defends closure process

Massachusetts at Boston, however, reported that the majority of patients moved from three public health facilities closed by the state are relatively satisfied with their new surroundings.

"Patient representative reports indicate that the Department of Public Health was generally successful in transferring patients smoothly in accordance with its plan," the study concluded. "Patient representatives were impressed with the quality of the new facilities."

The study was conducted by

the Gerontology Institute at the university.

Baker said the closing of the DPH facilities also saved \$20 million — money that was then invested in other areas.

"We take a lot of crap about being Republicans and being elitist... but we provided the same care or better to a primarily white, elderly population (in the hospitals) and invested the savings in a community system serving primarily a poor, minority and urban population," he said.

The closure of another of the nine targeted facilities — the Belchertown State School for the mentally retarded — also received high marks in a study by the Human Services Research Institute.

The study indicated families of retarded residents of the school overwhelmingly were satisfied with the move of residents to group homes in the community.

Most of the homes are operated by private vendors.

Even the most vociferous critics of privatization admit many vendors provide quality services.

The critics also concede private providers have often been more innovative in creating new programs and offer needed competition to state-run facilities and programs.

"There is a role for non-profit providers to deliver services to state," said Cliff Cohn of the Partnership for Quality Care, a group critical of Weld. "Many of them deliver good services."

□□□

The primary strike against Weld, say critics such as Cohn, is his full-speed-ahead plan for

privatizing more human services.

They claim the governor has rushed some of his privatization proposals without considering the consequences.

The closing of the Northampton State Hospital in western Massachusetts is a prime example, the critics claim.

The state Department of Mental Health has been forced to delay the closing of the hospital three times, in part, because of problems in finding private vendors who will absorb some of the long-term patients at Northampton.

The Senate Post Audit and Oversight Committee last month accused the DMH of attempting to shut down the facility without first considering the impact on patients.

"DMH seemingly decided to shut down the facility, transfer the patients, then establish the policy's impact," said state Sen. Thomas Norton (D-Fall River). "To say that they appear to be doing this backwards is an understatement."

Baker said he is "willing to eat some crow" on the Northampton shutdown.

"I'll be the first to admit it has taken longer than we thought," he said.

But Baker also defended the delay, saying it was the result of Weld's pledge not to move clients until equal or better care was found for them.

"We had a commitment to live up to and the fact that closure has been delayed a couple times is because of that commitment," he said.

Despite the problems at Northampton, the Department of Mental Health produced its own study indicating patients transferred from other closed hospitals were receiving the same or better care in private facilities.

Advocates for the mentally ill, however, claim Northampton is only symptomatic of larger problems with Weld's privatization plans.

Advocates say some clients discharged as a result of the closings of Metropolitan and Danvers state hospitals and the Gaebler Children's Center have wound up in homeless shelters, while others are going without needed treatment plans.

"I think the system has deteriorated," said Barbara Rhoda, the president of the Alliance for the Mentally Ill. "We were just starting to make some real progress. Things have gotten ten times worse."

□□□

While the closure of nine facilities in Gov. Weld's most ambitious privatization effort to date, it represents only a small part of the state's \$1.25 billion private human service network.

Experts who have studied privatization of human services — a phenomenon that has accelerated since the early 1970's — warn this system

airs problems and promise

faces potential fundamental breakdowns

For starters, a substantial number of vendors are in financial trouble.

A survey by the Social Policy Research Group of 514 private providers found one-third of the agencies reported operating deficits in fiscal 1991.

The survey found few agencies had access to endowments or other financial reserves to weather bad times.

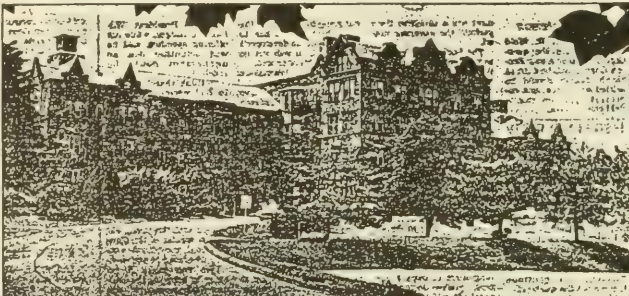
"Private providers of human services in the community are in deep trouble and, at the same time, are an increasingly important part of the larger system of care," the report concluded.

The state also runs a risk of becoming a captive of the private human services industry if funds, others warn.

A review of January 1993 spending by the Herald uncovered 17 human service vendors receiving more than \$1 million in contracts.

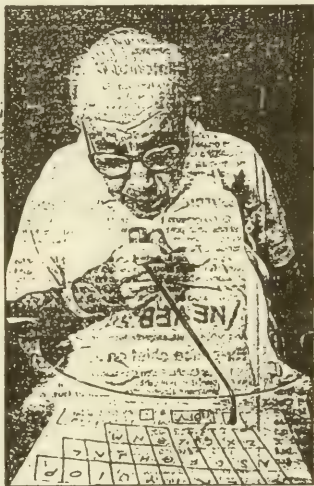
These so-called mega-vendors represent less than five percent of the total state spending.

Turn to Page 14



TROUBLES: Crisis site Northampton State Hospital, above, as an example of privatization without consideration for consequences.

Problems finding private vendors to absorb some long-term patients have played a part in delaying the hospital's closure three times.



CONTROVERSY: Perhaps the stiffest opposition to plans for closing state facilities came from a patient. Allan R. Smith, who has Lou Gehrig's disease, launched a hunger strike in an unsuccessful attempt to block shutdown of Lakeville Hospital.

State review raises questions about fiscal oversight of private vendors

By DAVID ARMSTRONG

During the past two years the state has quietly changed the way it keeps track of the \$1.3 billion it pays to private agencies to provide human services.

Instead of deploying a small army of state human service auditors to check up on vendors, the state now relies on private accountants — hired by the vendors themselves — to monitor how state dollars are spent.

In addition, the state has changed the basic financial reporting form for private providers, eliminating requirements that vendors report items such as automobiles owned or leased, real estate purchased or leased, and professional fees paid.

These changes concern State Auditor Joseph DeNucci, an elected Democrat who is auditing two dozen private agencies as part of a broad review of the state's human service purchasing program.

DeNucci's review, in turn, is troubling Wald administration officials.

"I believe the audit that (DeNucci) will eventually issue will be damaging to the progress that we are making in our reform efforts," Dana Roskiewicz, the head of the Division of Purchased Services, warned his superiors in a memo.

This audit, if lauded publicly, could renew the strength of many critics' arguments that the system needs far stronger

fiscal and administrative controls.

Robert Powliatta, the state's deputy auditor, said DeNucci's review has, in fact, unearthed troubling trends.

"The state wants to minimize oversight, but the system now is just a rubber stamp," he said. "The state has loosened up controls to the point there are no strings attached."

According to Roskiewicz's memo to his superiors, auditors from DeNucci's office have already uncovered a number of problems, including:

- A shocking number of related party deals — in which vendors do business with the corporations they control — and a failure to adequately disclose these transactions.

- A number of questionable transactions between private providers and their board members.

- Instances of vendors spending state money on luxury items, particularly "fancy cars."

Powliatta said the state's ability to ferret out these kinds of problems has been diminished by the elimination of in-house auditing by the Executive Office of Health and Human Services.

Beginning in 1990, a team of 37 auditors and investigators was gradually phased out through last year.

Today, the only regular auditing of state human service contracts is performed by four auditors working for Roskiewicz.

While Roskiewicz and his chief auditor, Kent Barabara, are given generally high marks for their work, they are clearly outgunned.

Administration and Finance Secretary Peter Neenan said he is proposing a \$500,000 increase in Roskiewicz's budget.

Some observers, however, said the continued reliance on private CPAs — hired by the providers — to audit financial returns of vendors leaves the state exposed.

An Internal 1991 state report claimed this relationship was hazardous to the state because private auditors would not be as aggressive as state auditors in unearthing problems.

"There is an inherent conflict of interest in the relationship," the report concluded. "If a CPA firm maintains complete objectivity reporting all adverse findings, it may not be hired to perform the review in subsequent years."

Roskiewicz, however, said this new system guarantees every private provider will be professionally audited. In addition, the private CPAs are now asked to make determinations about an agency's financial structure.

The audited financial returns will be used to compare vendors and set prices, a process that was impossible with the older financial returns, he said.

Neenan also said the conflict of interest issue is a bogus one, because CPAs wouldn't risk their license in order to please a vendor.

S

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**Privatization
plagued by
scarcity of
competition**

From Page 7

percent of all the human service providers doing business with the state. Yet they account for at least one-third of the money spent by the state on private care.

"There is a danger of big vendors swallowing up smaller ones," said John McManus, the executive director of the Massachusetts Council of Human Service Providers Inc. "We need something to encourage the smaller business."

In addition, many vendors now own large amounts of real estate used for group homes and other programs. This is a barrier for resource-poor start-up companies considering a bid on state contracts held by the larger agencies.

Overlan, a Republican researcher who studied privatization for the Beacon Hill Institute, said his work indicates a serious lack of competition.

Without competition, he warns, the state will never realize cost savings because the large vendors will end up dictating prices and standards to the state.

More importantly, Overlan said 20 years of privatizing human services has failed to yield any significant savings.

"No one has shown me this saves money," he said. "Privatization has not worked in the human service area."

End series

Tomorrow: James J. Kerans, Massachusetts secretary of transportation, and Joseph M. Bonavita, executive director of the American Federation of State, County and Municipal Employees, debate the merits of privatization.

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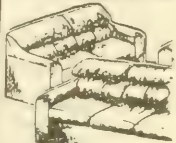
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AUDITOR

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

142 MAIN STREET, Room 501
BROCKTON, MASSACHUSETTS 02401

TFI (617) 727-8286
(508) 583 2098

April 26, 1993

Honorable Ron Wyden, Chairman
U.S. House of Representatives
Committee on Small Business
363 Rayburn House Office Building
Washington, D.C. 20515-6316

Dear Congressman Wyden:

Your letter dated April 5, 1993 requests additional information regarding the March 29, 1993 testimony before your Committee by officials from Auditor of the Commonwealth of Massachusetts, A. Joseph DeNucci's office.

We hope that the following information adequately responds to questions you raise on these important issues.

In response to Question 1a & b. (In what states is your office, in cooperation with the U.S. Department of Justice, conducting an ongoing investigation of Mentally Retarded and Developmentally Disabled (MR/DD) service providers. Specify the U.S. Attorney's office you are working with, and, the Assistant U.S. Attorney in charge of the case?):

- a) Rhode Island, Connecticut, New Jersey, Virginia, District of Columbia, New Hampshire, and Massachusetts.
- b) Michael Loucks, Assistant U.S. Attorney, Health Care Fraud Coordinator, 1st District, John W. McCormick Federal Court House Building, Boston, Massachusetts 02109. (1-617-223-9450)

John Pucci, Assistant U.S. Attorney, Federal Building, 1550 Main Street, Room 533, Springfield, Massachusetts 01103. (1-413-785-0237)

Kevin O'Reagan, Assistant U.S. Attorney, Federal Building, 1550 Main Street, Room 533, Springfield, Massachusetts 01103. (1-413-785-0237)

-2-

In response to Question 2, (Are questionable providers being investigated by the State of Massachusetts operating in states in addition to those that are subject to the joint Massachusetts/U.S. Justice Department investigation and the states where your office knows that questionable inter-state providers are operating?):

- a) None
- b) The possibility exists that providers in other states could be operating between states not known to us, such as, District of Columbia with New Jersey or New Jersey with Connecticut, etc.

In response to Question 3, (How long has this joint investigation been on-going?):

State Auditor A. Joseph DeNucci's office first contacted the U.S. Department of Justice in the Spring of 1988 as a result of preliminary audit findings that indicated fraudulent billing by certain providers to the Commonwealth, because federal funds were involved and it appeared the scheme went beyond the borders of Massachusetts.

Our auditors assisted U.S. Postal Inspectors in preparing a search warrant affidavit. The MR/DD provider's records were seized in December 1988 and placed in state custody because of our knowledge and experience with these state administered and funded programs.

Findings of fraud and corroborating evidence developed by our auditors and postal inspectors were presented by the U.S. Attorney to a grand jury in Boston, MA. Three individuals (two directors of the MR/DD provider and an associate) were indicted for racketeering and mail fraud.

Evidence developed in this proceeding indicated these three individuals were in business with three other people operating a similar enterprise in another area of the state.

This other enterprise was a multi-state provider which operated throughout New England and the mid-Atlantic states. We attempted to form a multi-state task force (copies of letters attached) without success. However, the contacts in other states allowed us to develop enough information to convince the Assistant U.S. Attorney in Springfield (MA) there was probable cause of criminal activity by another MR/DD provider. Again, Massachusetts state auditors assisted in the preparation of a search warrant affidavit, and the eventual search and seizure of records. These records are currently in our custody as this investigative audit proceeds.

-3-

In response to Question 4, (Have law enforcement officials in other states been notified of this investigation and/are they cooperating)?:

Yes, as mentioned in question three, it was the joint effort of state and federal investigators that resulted in the indictment and conviction of three individuals.

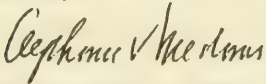
One of the biggest keys in the success of the (Boston) case was the ability of both offices to work cooperatively and professionally toward one common goal, the conviction. Information was always shared because the U.S. Postal Inspectors had the ability to focus on the overall fraud.

Because states have different regulations, it was decided (in the Springfield case) that the Office of Inspector General, U.S. Health and Human Services would become the lead investigative agency in the Springfield, Massachusetts case.

The ability to share relevant information with state law enforcement agencies has been limited at this time because of grand jury restrictions.

Should you have any further questions, please contact me at (617) 727-6296 or FAX (617) 727-8104.

Sincerely,



Alphonse V. Medonis, CFE
Regional Administrator/Director of Special Audits



A. JOSEPH DEMUCCI
AUDITOR

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE ROOM 1819
BOSTON MASSACHUSETTS 02108

TF1 (617) 727-6200

December 5, 1991

The Honorable Anthony Piccirilli
Office of the Auditor General
State of Rhode Island
100 Norwood Avenue
Cranston, RI 02905

Dear Auditor Piccirilli:

Preliminary results of an ongoing joint audit/investigation by the Massachusetts State Auditor's Office and federal authorities indicate that a Massachusetts based management company has devised a scheme to defraud various state funded agencies through a series of undisclosed related party transactions.

There are indications that this company is operating and controlling not-for-profit human service agencies in other states as well. These funded agencies obtain various goods, services and retail property from for-profit companies and realty trusts partially owned and operated by the owners of this company. The amount paid by the non-profit agencies for goods, services and leases is substantially higher than the actual cost paid by the for-profit companies which are also controlled by the management company. This results in excessive costs to your state. The dollar impact this scheme could have on your state's ability to fund community based residential programs is substantial.

We believe this group is actively operating in seven northeast states (including yours). We estimate the scheme, over a five-year period, has siphoned off over 10 million dollars.

Creation of a multi-state cooperative effort consisting of state and federal auditors, investigators and prosecutors could result in recoveries which would be in the best interest of our respective governments.

To maximize the efforts of this task force, we are requesting that you communicate to us information on the following not-for-profit human service agencies:

Ocean State Community Resources, Inc.

Additionally, please provide the following:

(a) Any audit, management or internal report issued or otherwise, for the last five fiscal years starting with F/Y 91.

(b) Any internal documents, workpapers, organization charts, trust documents or any other document you deem necessary.

(c) Statutes or regulations, both federal and state, regarding related party transactions within your state's jurisdiction.

In Massachusetts, our joint, cooperative audit/investigation has resulted in the indictment of three individuals, five corporations and five realty trusts that were part of a multi-million dollar alleged scheme to defraud the Massachusetts Department of Mental Retardation and Department of Mental Health.

We would like to arrange a meeting at a mutually convenient site and time to discuss your involvement in the multi-state effort.

For further information, please contact me at your earliest convenience at (617) 727-6200 x37.

Sincerely,



ROBERT A. POWILATIS
Deputy Auditor for Audit/Investigative Services

RAP/CAM



A. JOSEPH DRNICCI
AUDITOR

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE, ROOM 1819
BOSTON, MASSACHUSETTS 02108

TEL (617) 727-6200

December 5, 1991

Henry L. Becker, Jr.
Leo V. Donohue
Office of the State Auditor
Room 114
State Capitol Building
Hartford, CT 06106

Dear Auditors Becker and Donohue:

Preliminary results of an ongoing joint audit/investigation by the Massachusetts State Auditor's Office and federal authorities indicate that a Massachusetts based management company has devised a scheme to defraud various state funded agencies through a series of undisclosed related party transactions.

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1. Connecticut Community Services, Inc.
2. Charter Oaks, Inc. (formerly known as) Connecticut Community Support Services

Additionally, please provide the following:

(a) Any audit, management or internal report issued or otherwise, for the last five fiscal years starting with F/Y 91.

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Deputy Auditor for Audit/Investigative Services

RAP/CAM



A JOSEPH DENUCCI
AUDITOR

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE ROOM 1819
BOSTON, MASSACHUSETTS 02108

TFL (617) 727-6200

December 5, 1991

The Honorable Richard L. Fair
Office of Legislative Services
Office of the State Auditor
CN067
Trenton, NJ 08625-0067

Dear Auditor Fair:

Preliminary results of an ongoing joint audit/investigation by the Massachusetts State Auditor's Office and federal authorities indicate that a Massachusetts based management company has devised a scheme to defraud various state funded agencies through a series of undisclosed related party transactions.

There are indications that this company is operating and controlling not-for-profit human service agencies in other states as well. These funded agencies obtain various goods, services and retail property from for-profit companies and realty trusts partially owned and operated by the owners of this company. The amount paid by the non-profit agencies for goods, services and leases is substantially higher than the actual cost paid by the for-profit companies which are also controlled by the management company. This results in excessive costs to your state. The dollar impact this scheme could have on your state's ability to fund community based residential programs is substantial.

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To maximize the efforts of this task force, we are requesting that you communicate to us information on the following not-for-profit human service agencies:

1. Center for Humanistic Change of N.J. Inc.
2. Executive Management Associates, Inc.

Additionally, please provide the following:

(a) Any audit, management or internal report issued or otherwise, for the last five fiscal years starting with F/Y 91.

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Sincerely,



ROBERT A. POWILATIS
Deputy Auditor for Audit/Investigative Services

RAP/CAM



A JOSEPH DENUECCI
AUDITOR

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE ROOM 1819
BOSTON, MASSACHUSETTS 02108

TEL (617) 727-6200

December 5, 1991

The Honorable Walter J. Kucharski
Auditor of Public Accounts
P.O. Box 1295
Richmond, VA 23210

Dear Auditor Kucharski:

Preliminary results of an ongoing joint audit/investigation by the Massachusetts State Auditor's Office and federal authorities indicate that a Massachusetts based management company has devised a scheme to defraud various state funded agencies through a series of undisclosed related party transactions.

There are indications that this company is operating and controlling not-for-profit human service agencies in other states as well. These funded agencies obtain various goods, services and retail property from for-profit companies and realty trusts partially owned and operated by the owners of this company. The amount paid by the non-profit agencies for goods, services and leases is substantially higher than the actual cost paid by the for-profit companies which are also controlled by the management company. This results in excessive costs to your state. The dollar impact this scheme could have on your state's ability to fund community based residential programs is substantial.

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Job Discovery, Inc.

Additionally, please provide the following:

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ROBERT A. POWILATJS
Deputy Auditor for Audit/Investigative Services

RAP/CAM



A JOSEPH DLUCCI
AUDITOR

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE, ROOM 1819
BOSTON, MASSACHUSETTS 02108

TFL (617) 727-6200

December 5, 1991

Ellen M. O'Connor
Deputy Mayor for Finance
1350 Pennsylvania Avenue, N.W.
Room 423
Washington, D.C. 20004

Dear Ellen:

Preliminary results of an ongoing joint audit/investigation by the Massachusetts State Auditor's Office and federal authorities indicate that a Massachusetts based management company has devised a scheme to defraud various state funded agencies through a series of undisclosed related party transactions.

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1. D.C. (District of Columbia) Community Services, Inc.
2. Center for Humanistic Change

Additionally, please provide the following:

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ROBERT A. POWILATIS
Deputy Auditor for Audit/Investigative Services

RAP/CAM



A. JOSEPH DeNUCCI
AUDITOR

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE, ROOM 1819
BOSTON, MASSACHUSETTS 02108

TEL (617) 727-6200

December 5, 1991

Edward V. Regan
State Comptroller
Office of the State Comptroller
A.E. Smith Office Building
Albany, NY 12236

Dear Comptroller Regan:

Preliminary results of an ongoing joint audit/investigation by the Massachusetts State Auditor's Office and federal authorities indicate that a Massachusetts based management company has devised a scheme to defraud various state funded agencies through a series of undisclosed related party transactions.

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To maximize the efforts of this task force, we are requesting that you communicate to us information on the following not-for-profit human service agencies:

1. New Directions in Human Services, Inc.
2. New Directions in Health Care, Inc.

Additionally, please provide the following:

- (a) Any audit, management or internal report issued or otherwise, for the last five fiscal years starting with F/Y 91.

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ROBERT A. POWILATIS
Deputy Auditor for Audit/Investigative Services

RAP/CAM



A. JOSEPH D'NUCCI
AUDITOR

The Commonwealth of Massachusetts

AUDITOR OF THE COMMONWEALTH

ONE ASHBURTON PLACE, ROOM 1819
BOSTON, MASSACHUSETTS 02108

TEL (617) 727-6200

December 5, 1991

Charles L. Connor
Legislative Budget Assistant
Office of the Legislative Budget Assistant
State House, Room 102
Concord, NH 03301
ATTN: Michael Buckley

Dear Mike::

Preliminary results of an ongoing joint audit/investigation by the Massachusetts State Auditor's Office and federal authorities indicate that a Massachusetts based management company has devised a scheme to defraud various state funded agencies through a series of undisclosed related party transactions.

There are indications that this company is operating and controlling not-for-profit human service agencies in other states as well. These funded agencies obtain various goods, services and retail property from for-profit companies and realty trusts partially owned and operated by the owners of this company. The amount paid by the non-profit agencies for goods, services and leases is substantially higher than the actual cost paid by the for-profit companies which are also controlled by the management company. This results in excessive costs to your state. The dollar impact this scheme could have on your state's ability to fund community based residential programs is substantial.

We believe this group is actively operating in seven northeast states (including yours). We estimate the scheme, over a five-year period, has siphoned off over 10 million dollars.

Creation of a multi-state cooperative effort consisting of state and federal auditors, investigators and prosecutors could result in recoveries which would be in the best interest of our respective governments.

To maximize the efforts of this task force, we are requesting that you communicate to us information on the following not-for-profit human service agencies:

1. Center for Humanistic Change
2. New Hampshire Residential Programs, Inc.

Additionally, please provide the following:

- (a) Any audit, management or internal report issued or otherwise, for the last five fiscal years starting with F/Y 91.

(b) Any internal documents, workpapers, organization charts, trust documents or any other document you deem necessary.

(c) Statutes or regulations, both federal and state, regarding related party transactions within your state's jurisdiction.

In Massachusetts, our joint, cooperative audit/investigation has resulted in the indictment of three individuals, five corporations and five realty trusts that were part of a multi-million dollar alleged scheme to defraud the Massachusetts Department of Mental Retardation and Department of Mental Health.

We would like to arrange a meeting at a mutually convenient site and time to discuss your involvement in the multi-state effort.

For further information, please contact me at your earliest convenience at (617) 727-6200 x37.

Sincerely,



ROBERT A. POWILATIS
Deputy Auditor for Audit/Investigative Services

RAP/CAM

TO: Ron Wyden, Chairman
Committee on Small Business
Subcommittee on Regulation, Business
Opportunities and Technology

FROM: Thomas G. D'Luge

RE: Written testimony for Subcommittee
hearing to be held Monday, March 29, 1993 at
2359 Rayburn House Office Building
Washington, D.C.

WRITTEN RESPONSE TO SUBCOMMITTEE ISSUES

1. Alternative Services collectively consists of five nonprofit 501(c)(3) tax exempt corporations. It commenced operations in Michigan in 1978. In response to a decision made by the Department of Mental Health in Michigan to relocate certain residents from an institution setting it submitted proposals to operate group homes to various mental health agencies.

Alternative Services through its collective nonprofit agencies currently operates eight (8) community base group home facilities in Connecticut, twelve (12) community group homes in Florida, twenty-eight (28) community based group homes in Michigan and twenty (20) community based group homes in Oregon. It further provides supervision for clients in these states in less restrictive environments who live in apartment settings. These clients have transitioned into the more cost effective semi-independent living environment after receiving rehabilitative and program services in more costly group home residential operated by Alternative Services, Inc.

Ownership of facilities varies based primarily on state procedures and the availability of suitable facilities. For example the State of Michigan currently leases most facilities from third parties and then sublets them to a provider such as Alternative Services. In Oregon, a state related agency, Northwest Housing Associations, purchases existing or constructs new facilities which are leased to Alternative Services with the exception of one house which was a related purchase at the request of Oregon's Department of Mental Health who was unable to arrange for the purchase of the special facility. Of the sixty-eight (68) facilities operated by Alternative Services agencies in these four states, less than twenty (20%) percent are owned by related parties or entities.

Facility site selection is either a joint decision between the respective state agency and Alternative Services or is exclusively determined by the state agency. Michigan and Oregon's agencies generally select the site. Most of the Michigan facilities have been in existence for quite some time due to its longer history of

community placement. They have recently replaced older leased facilities with newer more energy efficient handicapped accessible models. Oregon's housing association favors new construction when possible based on the needs of the clients selected for the facility.

New construction in which the states are involved are generally funded by tax exempt municipal bonds. Other nonprofit housing agencies, such as the nonrelated Connecticut based Corporation for Independent Living purchases and renovates facilities using tax exempt bond funding. These facilities are then leased to operators having contracts with state agencies. Facilities which otherwise require building code or licensing renovations may be paid for by the operator who is generally reimbursed for these expenses over an amortized period.

2. Alternative Services collectively provides around the clock care for three hundred forty-five (345) clients in group home facilities and for another ninety-nine (99) clients in the less restrictive Whole Life/Supported Independent Living setting. Group home facilities are separately standing "Single Family" residential structures of two to five bedrooms housing six or less residents.

These facilities are generally placed in community settings i.e., subdivisions but may also be located in country settings affording somewhat larger yards.

Whole Life/Supported Independent Living settings are generally apartments or condominium units usually shared by two residents.

3. Quality assurance is a shared provider/state responsibility which is systematically provided through multiple state and federal agencies mandated to monitor provider compliance, as well as internal Alternative Services, Incorporated policy controls intended to maintain employee and program operations in compliance with regulatory standards.

External agencies which provide governmental oversight in each state include HCFA, state licensing divisions, responsible state mental health case management agencies, state entities for ICF inspections, state or local fire marshall offices, and so forth. Contracts with responsible mental health agencies also require providers to cooperate fully with other state-supported entities who may conduct as-needed investigations into allegations and complaints from any reporting source on issues of substandard client care, abuse or neglect. Such governmental entities include offices of Recipient Rights, Protective Services, Licensing Bureaus, State or local police officials, etc.

State and federal standards establish quality assurance monitoring of each client's placement via the responsible mental health agencies case management system. Implementation of client's plans of service are subject to weekly and monthly reviews by the

caseworker, quarterly program case notes on client IPS goals, mid-year IPS reviews by the Interdisciplinary Team (I-Team), and an annual assessment and redevelopment of each client's plan of service.

Alternative Services has also established policies and procedures to provide internal oversight of client care on a continuous basis. Recently the agency has developed and implemented discipline-specific audits targeted to monitor monthly clinical support services to clients, and to assess the quality of client services received from clinical support staff for compliance with governmental standards. The agency also requires on-site ASI management staff to provide bi-monthly Q.A. audits, and recommendations to mid-level ASI supervisory staff so that routine problem-solving discussions occur within the agency. Mid-level supervisors conduct comprehensive administrative audits on an annual or more frequent basis, and the agency contracts out for unannounced audits on a random sampling of programs as a means for instituting a check and balance on the reliability of audit information received through ASI management and supervisory staff.

Alternative Services is an equal opportunity employer and maintains employee recruitment strategies required by law and standard to any business organization. As vacancies occur, positions are posted internally within the company to encourage employee advancement if possible; help wanted ads are purchased in local newspapers; and postings may be placed with college placement services. Because Alternative Services is a known and respected agency, unsolicited inquiries for employment occur by mail, and through informal networking by employees' acquaintances who are seeking employment. The agency also works with private temporary help agencies, and state unemployment services offices.

The Alternative Services employee recruitment policy guidelines are written for compliance with state-specific standards for employee eligibility, i.e. employee's age, emotional and physical health, education, good moral character, and police background clearance.

Upon acceptance of an offer for employment with the company, new employees are required to complete a six (6) month orientation period, during which time employees receive basic training in their job responsibilities and duties, as well as training in state-mandated topics. States have varied training standards, but generally ASI employees complete at least eighty (80) hours of pre-service and in-service training during the first six months of employment.

Alternative Services also requires during each successive year of employment that employees attend up to thirty-two (32) hours per year in agency sponsored training on specific topics identified by ASI. Program audit data, employee training need surveys, and

company-driven needs regarding agency policies, work conditions, governmental regulations, or changes in client care requirements provide more than ample material for identifying agency staff training needs.

Alternative Services reviews and establishes annual employee wage and fringe benefit guidelines for its employees. The entry-level and maximum wages affordable, as well as the benefits provided by ASI in each state, are limited by the funding levels established by state contract for the personnel schedule of the home budget. Employee pay increases are similarly limited by the availability of funds in the personnel schedule, but generally direct care employees are eligible for a pay increase at the completion of their orientation period, and annually if a cost of living increase is received from state agencies for the personnel schedule.

Client services for out-of-home day programs, as well as in-home support services, are generally addressed in each client's annual plan of service established by the client's Interdisciplinary Team, and contract funds are provided through the responsible mental health agency for these services. School-age residents attend local schools. Client pre-vocational and employment services are either contracted to a third party vocational service agency, or if none exist, are contracted with the residential provider for such services. It is the responsibility of the mental health case management agency to assure that an arrangement exists for vocational support services.

Client support services are the responsibility of the mental health placement and contract agency. As a rule, case management services remain a primary responsibility of the mental health agency as an oversight and service coordinating role. Other essential clinical services such as nursing and behavior management are funded in some cases with the residential provider or to a third party private or state agency. Additional client clinical needs for dietary, psychiatric, O.T., P.T., etc. are established on an as-needed basis by the I-Team. Funding for these auxiliary services may or may not be contracted through the provider from the state.

Client medical and physical oversight is provided by a nurse hired or assigned to ASI, a community-based primary care physician established for each home, continuous monitoring by the caseworker and the Interdisciplinary Team, and obviously ASI's program staff. Alternative Services also has established internal policies and reporting systems for unusual incidents or changes in a resident's medical status. Such reports are forwarded to the responsible mental health casemanager as they occur for assistance and follow-up.

Concerns of parents, relatives, guardians, or clients are routinely dealt with at the home level where problem-solving is immediate and best effected. Concerned individuals or residents also have access to mid-supervisory level and administrative staff through company policies should lower level problem-solving efforts be unsatisfactory. In all but a very few situations the informal grievance protocol of Alternative Services appears to be sensitive and responsive to client/parent/guardian needs.

The Recipient Rights system is also available to anyone who wishes to express serious concerns about client services, treatment, or abuse and neglect. ASI policy and state regulations provide individuals with a reporting tool that involves the responsible mental health agency in conflict resolution situations or more serious concerns. The complaint/grievance process allows complainants to file their concerns with complete anonymity directly to state agencies.

Guardian's parent's, and client's concerns can also be channeled to the responsible mental health casemanager at any time, and emergency I-Team meetings can be arranged to address such issues. The I-Team process and federal and state regulations require that client and parental/guardian consent shall be solicited and documented as part of any I-Team planning and decision making process.

4. Alternative Services programs are subject to numerous announced and unannounced inspections and visits. Family, guardians and friends of the residents are generally afforded unrestricted access to our residents. We extend every courtesy and opportunity to such visitors as we think such contact is beneficial to the clients interpersonal interactions. We are further subject to such inspections by numerous agencies of each state mental health system. The inspectors represent such department branches as Social Services or Human Resources. State mental health; regional or community mental health and public health agencies. Federal Health Care Finance Administration inspectors will further inspect for compliance with ICF/MR and HICFA standards. There are further state and federal agencies empowered to act on behalf or to protect clients rights. The specific agency name usually varies per state but are commonly called "Office of Recipient Rights" or the "State Advocacy Office".

5. Historically Alternative Services performed its basic accounting, payroll and training services in house. Considerable sums were expended in the mid 1980's to develop computer software and accounting procedures to meet the ever changing detailed accounting requirements of the state and federal government. Similarly Alternative Services recognized the need to provide periodic employee in-servicing for "refresher". and "updating" issues deemed critical to the providing of quality services.

Specific seminar presentations and manuals were created.

Alternative Services was approached by smaller provider agencies as well as "Mom and Pop" group home providers who inquired about these accounting and training techniques which would be difficult to develop by providers without adequate volume funding. Based upon the companies belief that it had developed accounting and training systems that would be beneficial to other providers of community placement services, two for profit subsidiaries were incorporated in the later part of 1987. These for profit entities currently provide accounting and training services for both ASI and non ASI clients. Accounting subsidiary revenues are currently split approximately fifty/fifty between ASI and non ASI clients. The increased volume of revenues from the accounting services has enabled the accounting services subsidiary to both improve its expertise and reduce its charges for accounting services. All profit revenue to date received by the accounting and training entities have been retained by these entities and used to improve services. No Alternative Services entity or employee has received any compensation from these entities to date. During July and August of 1992, the Internal Revenue Service conducted a standard periodic audit of the Alternative Services entities including the relationship of the "For Profit" entities. All of the entities were found to be in full compliance of IRS tax exempt procedures. All of the nonprofit 501(c)(3) organizations are subjected to audits by several certified public accounting firms. These certified audits are timely forwarded to the appropriate state agency for its review. The auditors confirm our compliance with federally mandated accounting standards.

6. Alternative Services has developed a process called Habilitation Planning which is effectively a life history of the client needs and goals. It is designed to foster client growth in all life areas and to determine which areas require intervention. Habilitation Planning is developed on an annual basis in conjunction with the community and all service disciplines which provide intervention and treatment to the client. Client and family input in this process is extensive and much appreciated.

From the overall plan, an "ITP" is developed. This individual treatment plan is a very specific goal oriented chart for the resident. It organizes each discipline, its interventions and the results in the treatment plan. Each discipline becomes an integral part of the service planning process. An ITP team generally consists of representatives from the following sources: Community Case Manager; ASI representatives; all clinical disciplines serving the client (behaviorist, therapist, nurse); vocational program staff and client and family members.

The Individual Treatment Plan addresses goals outlined in the Habilitation Plan and provides for services to maximize behavioral stabilization, enhance appropriate community behaviors, increase

skill acquisition, and maintain or improve physical health. This plan is reviewed on a quarterly basis by the full team and revised if necessary. Minutes of the ITP team are kept which include staff participation, progress toward goals and recommendations for residential services. Between the team meeting the Home Manager completes a monthly progress report for the ITP team. The monthly report will include such things as behavioral services, skill acquisition, socialization, recreation and leisure activities, medical services and needs, family contact and school contact. Copies of the monthly reports are provided to family, clinical service providers, and to the Community Casemanager. This permits a prompt review or response to a client's needs.

Each of the specific topics reviewed in these reports are attuned to the individual needs of the client. Some of the topics are detailed as follows:

- A. **BEHAVIORAL PROGRAM SERVICES:** Behavioral intervention is provided that addresses the reduction of targeted behaviors that impede progress toward independence and community integration. Approaches are used that are non-aversive in technique, and do not incorporate the use of time-out, chemical restraint, or mechanical restraint. All behavioral interventions are treatment team reviewed and approved. Program emphasis is focused on reinforcement of appropriate behaviors.
- B. **SKILL ACQUISITION:** This program component addresses deficits in the areas of personal self-care, i.e. bathing, toileting, oral hygiene, dressing, home care, meal preparation, etc. Additional emphasis areas, when appropriate, include recognition of survival signs, shopping, and fund management. When a skill deficit is identified, a task analysis and data collection system are developed and implemented with a formal program.
- C. **SOCIAL/RECREATIONAL:** Social/Recreational experiences are offered to each client. This training focuses on those socialization skills which are either maladaptive or non-existent. Training encompasses such life areas as communication, decision making, negotiation, self-acceptance, relationship formation, and age appropriate interactions. In keeping with the principle of normalization, a wide variety of community based recreational experiences are offered. Key to this program component is the involvement of each client in the decision making process. When appropriate, weekly "home meetings" are held. In these meetings, clients participate in the decision making process of the home. Practice decision making and problem solving are key components in these sessions. Decisions regarding menu planning, activities, and

house rules are often made. Client growth is aided by acquiring communication, negotiation, and responsibility skills.

- D. **VOCATIONAL SERVICES:** For those individuals who will reside in this residential program, supported vocational services will be provided. Vocational placement will be the result of an in-depth vocational evaluation provided by Alternative Services, Inc. Upon team review of evaluation results, the Supported Employment Job Coach will develop individual work placements for each client and will provide follow-up services. Vocational services will be coordinated with the residential program to assure programmatic consistency.
- E. **MEDICAL SERVICES:** Alternative Services, Inc. provides comprehensive medical services to each of the clients served. The agency will employ an area wide nurse who will coordinate all services with the residential team and the Case Manager. Community resources will be utilized to meet all requirements for medical care as outlined in the IHP and ITP. Dental care is delivered in the same fashion.
- F. **PHARMACEUTICAL SERVICES:** Alternative Services, Inc. through third party billing and utilization of a community pharmacy will meet the pharmaceutical needs of each client. In addition to the basic prescription medication service, the pharmacy will also provide to the agency required medication reviews as mandated.
- G. **PSYCHIATRIC SERVICES:** Alternative Services, Inc. advocates the reduction of inappropriate or maladaptive behaviors through the use of consistent behavioral intervention. The use of psychotropic medications is only used in conjunction with a behavioral program. The agency will work closely with the community psychiatrist identified by the community. The psychiatrist is a vital and valuable member of the treatment plan.
- H. **FAMILY SERVICES:** Alternative Services, Inc. through the use of agency professional staff and community resources, provides services that foster positive relations between clients and their families. Among these services are:
 - 1. Encouragement of family visitation.
 - 2. Family counseling when needed.
 - 3. Family training in program concepts, as well as other individual needs that foster a successful family experience.

4. Bi-monthly family group meetings. Whenever possible, group meetings are arranged that foster a positive agency/family relationship. Group meetings are in addition to individual family meetings.

- I. **SPEECH/LANGUAGE:** In order to assure that each client has the ability to express his needs and preferences, speech/language services will be provided by a Speech Language Pathologist. If verbal communication is determined to not be possible, then alternative forms of communication will be identified.
- J. **OCCUPATIONAL THERAPY:** If it is determined by the treatment team that Occupational Therapy would be of benefit to any or all of the clients of this program, then such services will be provided by a contracted vendor.
- K. **DIETARY SERVICES:** Alternative Services, Inc. will contract with a state licensed Registered Dietician who will assess each client and develop appropriate menu cycles. Prior to the Dietician providing this service, each client will be evaluated by the primary care physician and a diet order obtained. The Dietician will meet on a quarterly basis with staff and clients to modify menus to assure that client preferences are being incorporated.
- L. **DOCUMENTATION/RECORD KEEPING:** It is the policy and practice of the agency that adequate and accurate documentation is maintained on each service component provided to clients. All record keeping is designed to assure that the agency is in compliance with all rules and regulations as mandated by the community and by the state licensing division. In many cases, the agency requires documentation in areas not addressed by rules and regulations. This is done to assure that program and service quality meet agency standards. Required documentation acts as a reminder to staff that position responsibilities must be performed and that accountability is maintained.

Although Alternative Services has developed and advocates the team concept of individual treatment plan it remains committed to exploring other types of treatment and/or services to benefit the client.

7. Alternative Services is subject to an incredible number of ever changing regulations and guidelines. Mental Health is a field of science and as such is in a constant state of flux as new theories are postulated and tested. Community placement is a relatively new mode of client environment in the history of mental health. Community placement has fostered the development of Lodge

programs and supported living as the clients skill levels improve. All of these programs are being constantly monitored both scientifically and financially to evaluate their effectiveness.

A separate and perhaps more significant source of changing regulations and guidelines is federally or judicially mandated deinstitutionalization decrees. These decrees always contain time lines for compliance. We believe that such mandated compliance dates are critical to improve the well being of the institutional populations. However, from a practical point of view, many states institutionalized systems are set in their ways and methods of operation and opposed to community placement which limit their budgets and threaten their job security. As a result a hodgepodge of residential care and accounting guidelines are developed with these subjective concerns. Quite often the regulations and standards developed are hybrids combining the peculiar requirements of the particular state agencies with federal procedures.

In addition to the regulations developed under this scenario, a community placement provider with perhaps little business experience must deal with a myriad of regulations of a technical nature, i.e., EPA required medical waste guidelines to OSHA standards and penalties for blood borne pathogen procedures. Personnel issues are never simple or clear. Do your hiring procedures and management decisions comply with ADA, Civil Rights, Employee Right to Know Regulations and Department of Labor guidelines? Did you timely obtain minimum wage waivers for your vocational training programs? Are you in full compliance with the state sales and use regulations, unemployment compensation and workmen compensation requirements? These are just a minor example of the many issues confronting a provider on a daily basis.

In regard to quality assurance regulations we are obligated to comply with both federal and state standards. In addition to Alternative Services "in house" and "contracted" quality assurance policies and audits, we participate in quality assurance programs performed by state and federal agencies. Generally each state will conduct a periodic inspection of the premises to determine if the physical plant meets the needs of its residents, conforms to code requirements and that both preventive and required maintenance is performed. Unfortunately not all of the standards are consistent. As an example, federal guidelines require hot water to be at a temperature that is ten degrees different from what the state requires. Most state Clinical quality assurance policies are generally well developed. Most states use a "team" concept for quality assurance as a part of each client's specialized treatment plan. This plan is monitored periodically by the team to determine if progress is being made towards its goals.

While the theory behind these policies is very positive, quite often, Mental Health department structure prevents these operations from working cohesively and efficiently. As an example, a state

may have a protective services department which has the exact same purpose and responsibility as another, i.e., Office of Recipient Rights. Alternatively, we experience situations where we are being ordered by one state agency to provide a certain service, i.e. "one to one coverage" when the contract neither requires nor provides for such an expense.

All states provide for its own quality assurance programs. Although any quality assurance program is welcomed, those that are conducted by the same state agency that is being reviewed could be less than objective in its evaluation of that agency's performance. Notwithstanding these concerns, however, the single largest problem confronting quality assurance is the lack of funding. Even the most dedicated mental health worker or public servant is limited in their abilities if their case load limits their participation to annual reviews.

Although from a simplistic viewpoint federally mandated regulations for client care and quality assurance could supersede nonconsistent state regulations, we believe that such an approach is not realistic when one considers that the overall goal for the client is not a uniform cookie cutter approach but one rather fine tuned for that community.

We suggest that each state conduct a forum where all facets of the industry participate and develop a community based plan which avoids overlapping responsibilities and inconsistent regulations while obtaining commitments to funding necessary to provide quality care at the care worker level. Improved training and funding at the direct care level is attacking the problem of quality assurance and "freedom from client abuse" at its roots.

Alternative Services has always allocated funds to pay for outside independent audits of the client treatment programs and the group home operations. Such an audit or review of procedures and client progress is very helpful in uncovering client abuse which through employee consort might otherwise go undetected.

8. The single most enlightening and unfortunately disturbing aspect of community placement is the poverty or below wage levels paid the direct care workers and community placement wage earners in general.

Community placement during its infancy was hailed as a new approach to mental health. It was finally acknowledged that mental retardation and developmental disabilities if not curable could be treated so that those afflicted could develop the personal skills and confidence necessary to allow them to become productive members of society. As with most new concepts skeptics were numerous. The only way community placement could get started was by promising that not only would it produce benefits for society but that mental health costs for care would be substantially reduced.

During this initial stage of community placement it was easy to justify the wage disparity between community placement provider wage and those paid at the state institutions. The first group of clients were generally the highest functioning and but for the fact that no other reasonable options existing, probably would not have been institutionalized. Progress was significant even with a minimum wage scale direct care force.

The success of the concept of community placement (not to mention its cost effectiveness) accelerated its growth. The federal courts were finally able to bring about changes in the institutional standards of care as it had an alternative to the institutions in-community placement. However, this growth brought about the need to provide services for a more demanding client with less skills, more behaviors and infirmities than those suffered by those currently serviced by community placement. These more demanding clients required more dedicated and more skilled staff to implement their service plans. Unfortunately, not only has the funding for wages and training needed to meet these higher skill levels not been forthcoming, funding has decreased when adjusted for inflation.

Alternative Services recognizing this dilemma, has invested in employee turnover studies and developed additional training for its staff to partially offset this disturbing trend. But such approaches cannot be expected to resolve the fundamental problems inherent in poverty or below poverty level wage scales.

An exhausting, extensive review of these particular issues recently came to print in the highly regarded RESIDENTIAL SERVICES AND DEVELOPMENTAL DISABILITIES IN THE UNITED STATES -- a national survey of Staff Compensation, Turnover and Related Issues. This study was published in 1992 by the American Association on Mental Retardation and is the collective efforts of David Braddock and Dale Mitchell of the Institute of the Study of Developmental Disabilities of the University of Illinois at Chicago.

This study reflects a comprehensive survey on a state by state basis of such things as the mean starting wages; mean average wages, average fringe benefits and employee turnover for community placement workers in a particular state as compared to the workers performing similar duties at state run institutions. Across the country the statistics were startling. Due to the limited time available to prepare testimony we were unable to obtain permission from the editors to cite their copyrighted materials. However, their study supports finding that direct care workers in community placement facilities are paid at poverty wage levels. Furthermore, a substantial disparity exists between their rate of pay and that afforded those in state institutions performing similar duties and that disparity has increased significantly during the past decade.

Their findings confirm studies performed by Alternative Services or in which Alternative Services participated. As an example, Alternative Services operates several group homes in Michigan under contract with a regional community agency. This same agency operates its own group homes for the same client population yet its per diem budget is one hundred thirty-four percent (134%) of the per diem budget paid to Alternative Services to operate a similar group home.

Alternative Services direct care staff wages varies per state. As of June 30, 1992 the average wage scale for these staff is as follows:

<u>State</u>	<u>Per Hour</u>
Florida	\$ 4.65
Michigan	6.11
Oregon	6.19
Connecticut	9.40

Almost universally, employees wages are controlled by the respective states. Each state will set a line item amount for employee wages. You either provide services for this amount or go out of business. These line item amounts may not be utilized for other expenses, i.e. administration. Whatever excess funds are left from these line items are cost settled and paid back to the state, but if you overexpend this on this line item you make it up with administrative line item funds. The line item for employee wages also includes payroll taxes and fringe benefits. Attached to this testimony are four graphs detailing what percentage of each line item dollar goes for these specific costs. You will note that from the attached graphs that Alternative Services spends generally between approximately one and one-half percent of its budget on training. Most of this is supplemental to that provided for or mandated by the state and federal government.

Unfortunately much of the effort and expense of training is wasted due to high employee turnover. In an effort to better understand the basis for employee turnover and therefore minimize its impact within those areas we could control (i.e. other than wage which are set by the state) employee turnover studies were funded for the years 1984 through 1988. The study obtained responses from almost eight hundred (800) former Alternative Services Michigan employees. This comprised almost ninety-five percent (95%) response rate. Their comments were categorized and are attached as the fifth graph. The predominant factor cited for quitting was insufficient pay by over thirty percent (30%) of the group. The second most frequently cited category was frustration level. The single most frequent response under this category was

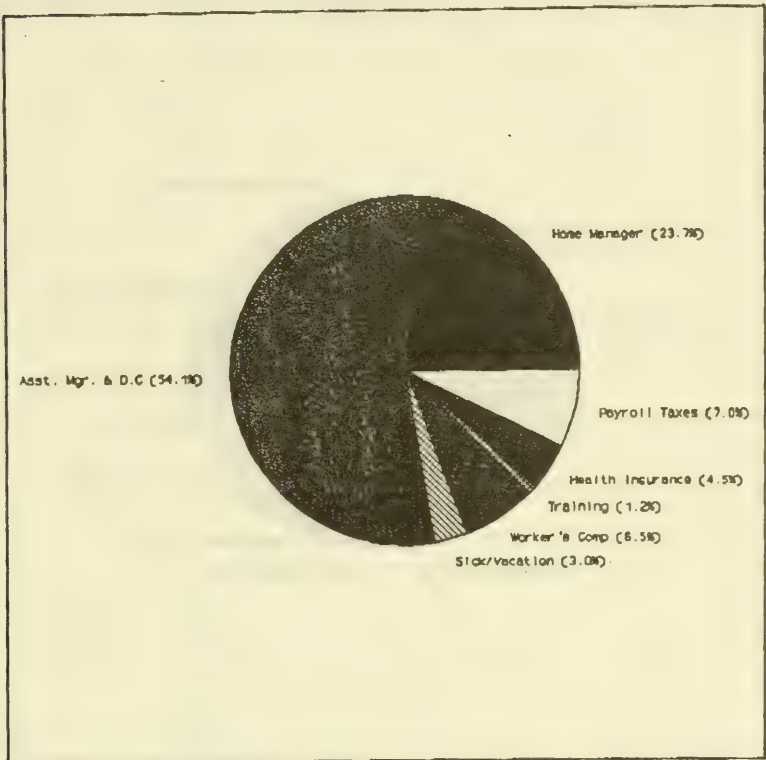
the belief that the direct care worker didn't believe that the responsible state agency or professional understood the difficulty of their task or appreciate their efforts.

The continued repression of funding by the state through continuation budgets and/or across the board cutbacks has increased the staff frustration levels and turnover rates. During the first part of the fiscal year ended September 30, 1992, Alternative Services, Michigan was experiencing a turnover rate of its direct care staff of approximately fifty percent (50%). The sixth graph attached reflects the reasons cited on their exit interview for resigning for 1991 and 1992. Insufficient wages was cited at a rate more than fifty percent (50%) greater than that cited by the 1984 through 1988 study.

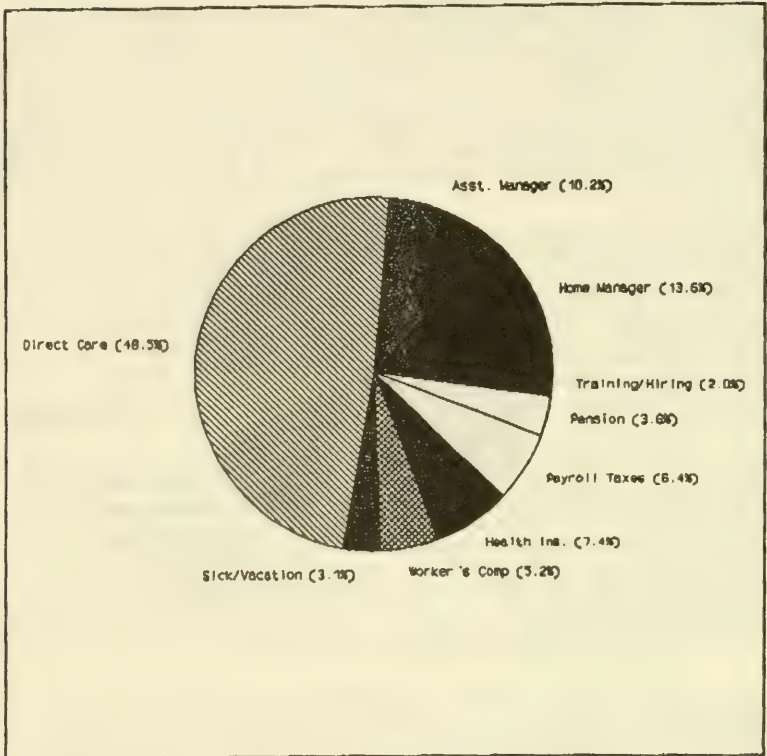
Despite these setbacks and difficulties, Alternative Services has developed plans and strategies to attract new employees. It offers health insurance and other benefits generally not available in other similarly wage scale industries. Whenever possible it takes advantage of such employee benefits as Section 125 cafeteria style benefit plans to minimize employee co-paid benefits. It further stresses its multi-state operation for employee and therefore wage advancement. This approach has been successful as the percentage of resignations citing "lack of advancement" has decreased in the most recent study.

In summary, Alternative Services, as most other providers in the community placement field, strive to do more than less. Expansion into other states and communities provide some relief in reduction of the percentage of revenues required by administration needs. It further allows for the acquisition of higher tech cost efficient procedures. It further affords the opportunity for constant review of your procedures required by the bid process and allows one to analyze the pros and cons of each states procedures, this resulting in an ever improving set of procedures by weeding out the less productive and fostering the progressive.

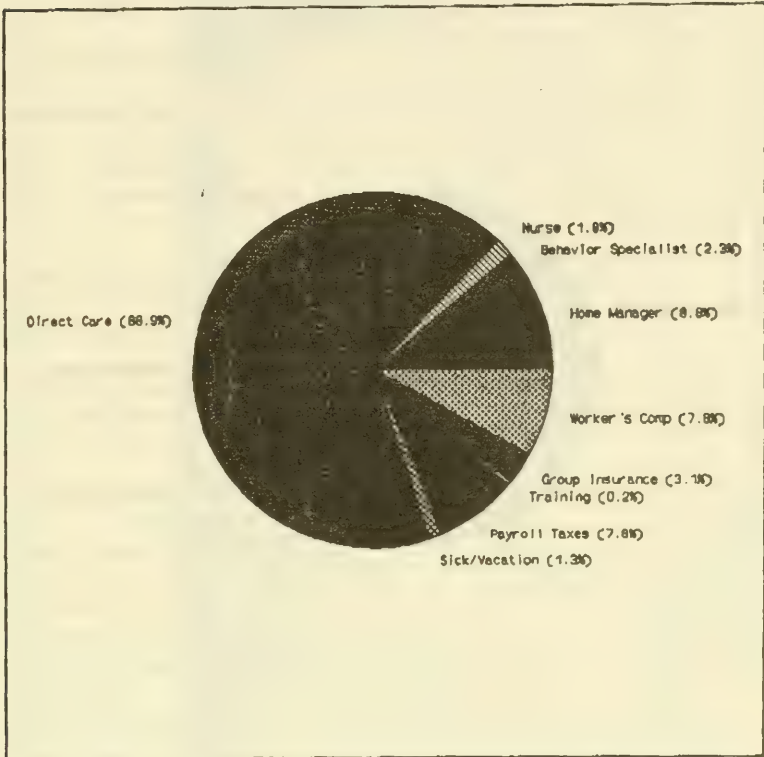
Notwithstanding these efforts, however, the bottom line remains that both the state and federal government must recognize the financial crisis affecting the community placement field. This administration recognizes and supports the need for investment in our future or we will all suffer the consequences. Unless a serious committee to funding community placement comparable to institution funding is not forthcoming, no further progress in mental health will occur and its remarkable progress to date will be jeopardized.

ALTERNATIVE SERVICES, INC. (FLORIDA)**Direct Service Funds - Salaries, Wages, and Fringe Expenditure Detail**

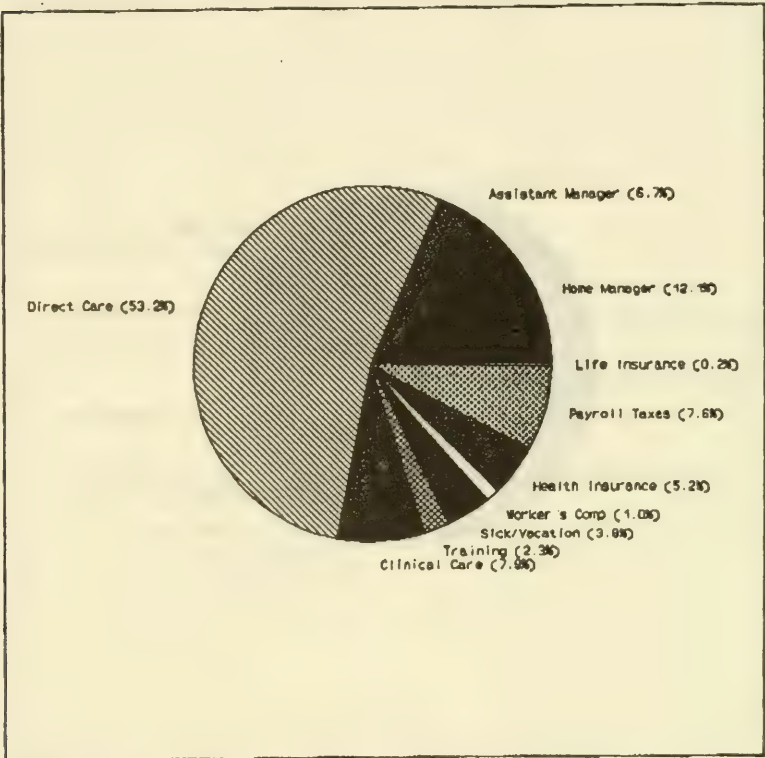
Average percentage of all expenditures within the Direct Service Staff Funding for the contract period ended June 30, 1992.

ALTERNATIVE SERVICES, INC. (MICHIGAN)**Schedule A - Salaries, Wages, and Fringe Expenditures Detail**

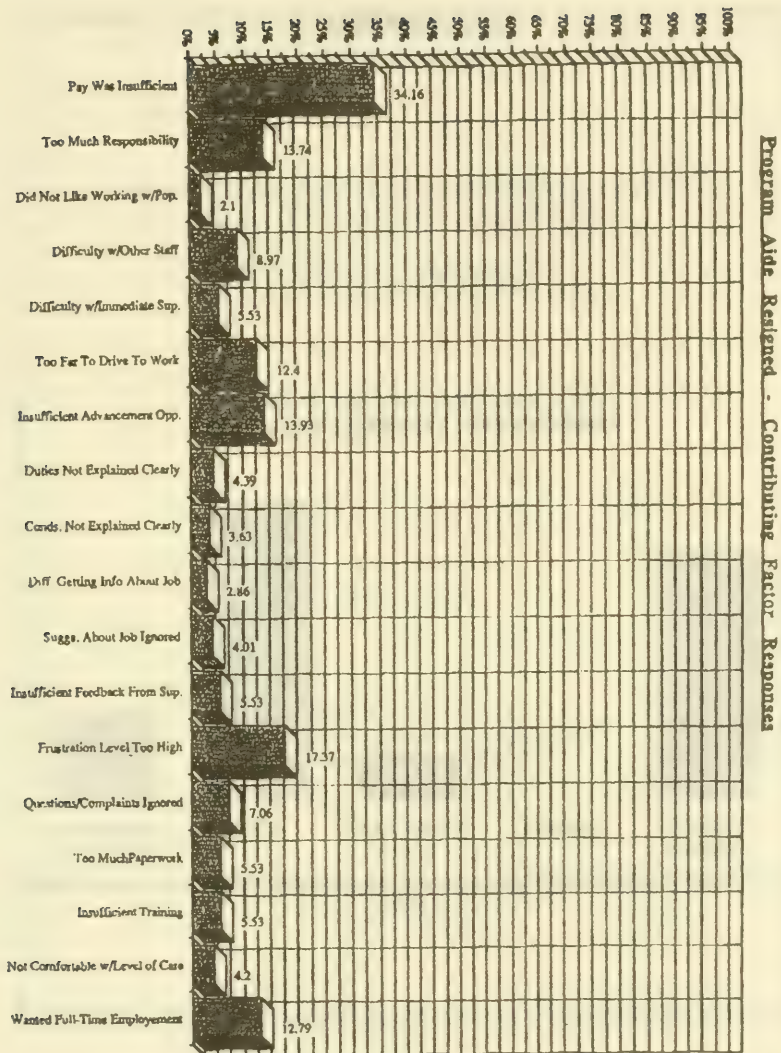
Average percentage of expenditures within Schedule A for the contract period ended 9/30/92.

ALTERNATIVE SERVICES - OREGON, INC.**Direct Service Funds - Salaries, Wages, and Fringe Expenditure Detail**

Average percentage of all expenditures within the Direct Service Staffing Funding for the contract period ended June 30, 1992.

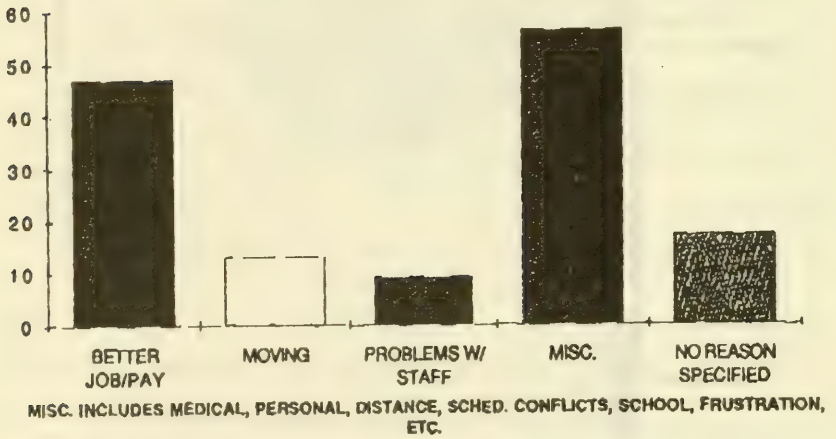
ALTERNATIVE SERVICES - CONNECTICUT, INC.**Direct Care Service Funds - Salaries, Wages, and Fringe Expenditure Detail**

Average percentage of all expenditures within the Direct Service Staffing Funding for the contract period ended June 30, 1992.



CHART/RESIG.REASONS

REASONS FOR 1991-92 RESIGNATIONS



UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON SMALL BUSINESS

Subcommittee on Regulation,
Business Opportunities and Technology

Ron Wyden, Chairman

TESTIMONY

BY

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Chairman, NYSDDP

March 29, 1993
Washington, DC

Good morning. My name is Ralph D. Farkas. I'm Executive Director of Professional Service Centers for the Handicapped, Inc. and Chairman of the New York State Developmental Disabilities Planning Council.

I'm here to testify on issues concerning community based provision of services for persons with developmental disabilities. I thank you for the opportunity.

PSCH is about people--those who serve and those who need services. We offer programs and services to change the lives of individuals who have mental retardation/developmental disabilities, and those with chronic mental illness. We are Professional Service Centers for the Handicapped, Inc., an agency guided by the belief that all people, regardless of their current level of ability, have the potential for personal growth and development.

PSCH is a leader in high quality, cost efficient services that address individual needs--residential services with a strong rehabilitative focus for individuals with psychiatric or developmental disabilities; family support services for these individuals and their families; programs that provide options and opportunities to enable individuals to reach their full potential.

Treat people as if they were
what they ought to be, and you
help them become what they are
capable of being

Johann von Goethe

PSCH recognizes individual differences, and the unique needs, desires and abilities of each person coming to us for service. Our underlying commitment is to the capacities, dignity and worth of the individual.

PSCH's services and programs provide opportunities for individuals to live and thrive in a community environment. We believe that each person is entitled to live where he/she chooses, and affirm that life in a community setting is the best place for individuals with disabilities to achieve their goals. Both Federal and State law supports this belief, and New York State has demonstrated a commitment to downsize and close institutions in favor of community based care and training.

To help individuals achieve their personal goals, PSCH offers:

- Community Based Residential Options:
A variety of living arrangements with a common focus on training, development, growth, and community integration.
- Family Support Services: To aid individuals and their families in planning, obtaining and coordinating services, including assistance in understanding options and exercising choices.
- Day Treatment: In PSCH Centers and other sites where participants are provided with meaningful weekday activities that are integrated and coordinated with the individual's overall rehabilitative plan. Day Treatment provides opportunities to develop the means to enhance the quality of life and increase independence.

- **Supported Work:** An innovative training and employment program to prepare individuals to enter the competitive work force.
- **Advocacy:** On behalf of all persons with disabilities to assure their rights and opportunities.

PSCH is a 501(c)(3) non-profit, non-sectarian agency founded in 1980, with award winning programs and services available to all regardless of race, religion, color, creed or ability to pay. We are licensed by the New York State Department of Mental Retardation and Development Disabilities (OMRDD), the New York State Office of Mental Health (OMH), and other State and City agencies. PSCH is a winner of the United Way of New York City Joseph Weber Award and has consistently been cited for the excellence of its programming and management.

Everyday we are faced with the challenge of providing quality services that are responsive to the needs of consumers. Toward this end, we must work to improve the overall quality of the workforce. The New York State Developmental Disabilities Planning Council (DDPC) of which I am the Chairperson, is a planning and advocacy body established under both Federal and State law.

DDPC sponsored a study of workforce issues in New York City. Findings were based on the responses of 700 employees of voluntary agencies from a cross-section of 24 agencies serving individuals with developmental disabilities. Respondents cover all services to individuals with developmental disabilities rather than just those involved in group community living situations.

Poor salaries were universally cited in this study and throughout the existing literature. This is, in part, due to a bias against women in caregiving occupations since 79% of the respondents were women. Similarly, salary-related issues were the most commonly cited reasons given by 79% of the employees leaving their jobs. However, salary alone was rarely the reason for direct care staff turnover. On the other hand, "advancement in the field" and "professional training" were among the most common reasons for employees accepting their jobs. Thus, agencies who make it easier for their employees to go back to school and get ahead are able to decrease employee turnover. Our own experience at PSCH is consistent with the findings of this study.

It is not enough to attract employees, you have to keep them. The goal is to improve the educational opportunities, training and career mobility of direct care workers both in the state and voluntary sector. Toward this end, PSCH has invested its own resources in the development of a PSCH training and education department which has developed a comprehensive training curriculum for our own employees.

We used our comprehensive training curriculum to develop a program to attract workers to the industry and provide them with training. In partnership with the NYS Department of Labor, using Economic Dislocation and Worker Assistance Act (EDWAA) funds, we offer a training program to retool unemployed workers for a different career path -- that of working with people with disabilities. We hope that recognizing where job opportunities are (and the human services field is a growth industry) and equipping workers for those jobs represents the wave of the future.

In New York State the Kennedy Fellows Program conducted a partnership with the NYS Office of Mental Retardation and Developmental Disabilities, Voluntary Providers, the City University of New York, the Center for Worker Education and the Kennedy Foundation. The program began as a certificate level program for direct care workers.

These are rare examples of funders recognizing that staff training and development are essential to quality service delivery, and that the costs associated with it need to be considered part of the cost of delivering quality services.

Under the leadership of Elin Howe, NYS OMRDD has spearheaded a change in the way the state provides services to a much more individualized approach. Simply put, that means service planning begins with the individual and family. Consumers and families, together with service providers, define those services the individual needs and wants. This represents a fundamental shift from a system that first designed a program and then fit people to it.

Why the change? First, because consumers want choice, because they want to be empowered to define what they want and need, and because, in the end, they know what is best, necessary and appropriate.

Equally important, by combining the individual service approach with an expanded array of service choices, we expect to serve more people. It is important to me as a service provider, to be able to offer services instead of waiting lists -- the new NYS Home and Community Based Waiver Service Program is just one example of a welcomed expansion and flexibility in offerings and in family eligibility for services.

This fundamental change calls for a different approach to accounting and regulation. We still need to know where the money is spent, that it is distributed to services, but also, whether the services are effective. The ability to monitor progress and analyze results is essential to success.

How do we evaluate quality services? How do we balance oversight and the burden that regulation is imposing on programming?

We believe that individuals with developmental disabilities and their families should be involved in the decisions that affect their lives. This begins with policy formulation and proceeds through program development and implementation to program evaluation and quality assurance efforts. The NYS BDPC and NYS OMRDD has begun with the development of a Consumer Opinion Questionnaire and an accompanying handbook to be used by individuals with developmental disabilities.

This instrument allows consumer involvement in program monitoring and review processes by providing an indication of consumer well-being and program responsiveness to consumer identified needs. After an intensive field test, the instrument has been released to the field. The next step is Consumer Advocate Review and Evaluation process (CARE). This third party monitoring process will allow consumers and advocates the opportunity to participate directly in quality assurance efforts. While the latter is in the early stages of development, it offers an opportunity for consumer involvement in determination of program compliance with federal and state regulation. The final step in this multi-stage project will be public education and training programs to encourage use of Consumer Opinion Questionnaire and Consumer Advocate Review and Evaluation.

Throughout the above described process, a major question from providers and advocates has been whether this is a new mandate. It is not. We are not promoting new regulations; we are, however, insisting on greater accountability to program consumers. Acceptance and use of Consumer Opinion Questionnaire and CARE should reduce reliance on regulatory surveys as the sole mechanism for insuring quality of care and responsiveness of programs to individual needs.

While the consumer ultimately tells us whether the services are of value, government agencies, such as NYS Commission on Quality of Care and the service provider are responsible for monitoring and evaluation of services and accounting practices. The need for sound accounting practices and controls for non-profit providers is no different than in the profit world. While internal controls are necessary to ensure that funds flow in an effective manner, this alone does not ensure quality services. However, poor quality services are often an indicator that sound financial management is absent.

Some specific recommendations the NYS Commission on Quality of Care already employs can be replicated nationwide are:

- . requirement for annual certified audits, properly trained board members with a clearly articulated fiduciary role in overseeing and protecting the assets of the corporation licensed to provide services.
- . strong disclosure, receivership, condemnation, and program fraud statutes that allow government to take over problem agencies and or remove executives or board members.
- . audits to examine spending practices and as an enforcement tool in revoking licenses.
- . funding incentives to reward good care.

I came here today proud of the way Professional Service Centers for the Handicapped provides services to individuals with disabilities.

I also came to endorse the movement that increases consumer and family involvement and empowerment, and to applaud the shift to more individualized services.

With national attention focuses on the provision of health and long-term mental health care and services for people with disabilities, we are poised to form a necessary strong partnership among consumers, government, community and service providers. I look forward to participating in developing that partnership, and in the shaping of future services.



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STATEMENT OF TESTIMONY

on the

STATUS OF RESIDENTIAL SERVICES AND COMMUNITY SUPPORTS FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Respectfully Submitted for the Record

to the

HOUSE SUBCOMMITTEE ON REGULATION, BUSINESS OPPORTUNITIES, AND TECHNOLOGY

THE HONORABLE RON WYDEN, CHAIRMAN

Presented by

Bonnie-Jean Brooks
Executive Director of OHI in Bangor, Maine
and
NAPRR Vice President for Policy

March 29, 1993

NATIONAL ASSOCIATION OF PRIVATE RESIDENTIAL RESOURCES
THE STATUS OF RESIDENTIAL SERVICES AND COMMUNITY SUPPORTS FOR
PEOPLE WITH DEVELOPMENTAL DISABILITIES

INTRODUCTION

The National Association of Private Residential Resources greatly appreciates being asked to testify as this Subcommittee addresses the important issues related to community services for people with mental retardation and other developmental disabilities. NAPRR currently represents more than 550 agencies across the nation that together provide residential services and community supports to more than 40,000 people with mental retardation and other developmental disabilities. Our members offer a full range of supports in a variety of settings designed to enhance the development and self-dependence of those served. They include for-profit, not-for-profit, church-related and small unincorporated family care providers who may: provide supports to people in their own homes, contract for services in a home owned by the person who provides support, and/or operate multiple sites and sizes of homes in one or more states, with all possible combinations of the above. Some members also offer daytime services and employment support.

As people with disabilities have presented the need for and requested a variety of services and supports, NAPRR members have been quick to try to respond to those needs. Ours is a rapidly changing field. Over the past couple of decades people providing services have become better listeners and have a better understanding of human potential. It is the people with disabilities themselves who are changing the system, and providers are challenged to keep up with them.

It is testimony to the ever evolving nature of service delivery, to the direction that supports and services have taken over the past two decades, and to Congressional vigilance over the health and safety of people with disabilities

that this Subcommittee is focusing attention on the fulfillment of the promise offered by the provision of community services. The concept that all people are capable of growth and development applies equally to service delivery systems. We are in a continually evolving field that seeks to be responsive to new understandings of best practice.

Just as it was appropriate for Congress to question and examine the services provided to people in large state institutions, it is now appropriate for this body to be assured that the wide range of supports offered in the community provide the promised opportunities for maximum independence, productivity and integration. Providers of all types should be challenged to provide services and supports in a cost efficient and effective manner which ensures human development while protecting the health and safety of their "customers."

We would like to begin by saying that there is no such thing as a service model that is appropriate for all people. Services should be driven by people who are offered a variety of supports and an opportunity to make informed decisions about where to live, work, receive medical services and therapies, and spend their leisure time. As stated in our association's statement of "Guiding Principles" (copy attached as Appendix A):

We who offer services and supports to people recognize that each individual should be offered opportunities to enhance and increase informed decision-making through a spectrum of expanding and continuing choices concerning: where one lives, services one receives, with whom one associates, and enrichment opportunities in which one participates.

Our "Guiding Principles" go on to articulate the supports to which we believe people are entitled, the role of those who offer services and supports and the

fact that NAPRR promotes an optimal quality of life to increase self-dependence, productivity, well-being and community integration for those who receive supports.

Over the past two decades, the system of residential services has increasingly moved toward smaller and smaller individualized homes in the community. Some of the driving forces in this movement are:

- o Personal Preferences,
- o Successful Experiences,
- o Funding Realities and
- o Statutory and Regulatory Requirements.

Each of these presents both opportunities and challenges to those who are struggling to offer the highest quality of services possible, to as many people as possible, with fewer dollars and ever increasing regulations. All of the factors are also affected by fluctuating political and economic influences.

We would now like to examine each of these driving forces individually and in reverse order.

FACTORS DRIVING THE SERVICE SYSTEM TODAY

A. STATUTORY AND REGULATORY REQUIREMENTS

Regulations imposed upon residential services and supports are designed to assure that the health and safety of the people served are protected. Program rules attempt to govern the delivery of services, and other rules protect the people who directly provide services. All of these are promulgated to improve lives, but collectively they sometimes have the opposite effect.

Providers are often subjected to a dozen or more surveys and other inspections within a single year. These range from voluntary accreditation such as that provided by The Accreditation Council for Services for People with Disabilities (otherwise known simply as The Accreditation Council), to mandatory

Federal and/or state requirements like licensing and certification visits, the local fire marshal, department of health, and many more. Sometimes the codes or standards applied are contradictory. It is difficult to promote freedom and independence with the "right to risk" when rules require that the people served have staff present at all times, for example. The Dan Piraro drawing which appears as Appendix B of this testimony illustrates the way many providers feel when confronting the variety of standards and rules that apply to them. At times it seems that providers are totally surrounded by obstacles to service delivery.

ICF/MR Standards - The Medicaid program supporting intermediate care facilities for people with mental retardation (ICF/MR) requires that all people served "must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services" (Code of Federal Regulations Part 42, section 483.440(a)). This language is intended to assure that interactions will advance objectives established by each person's interdisciplinary team, which are contained in the individualized program plan. Implementation of programs of active treatment unfortunately sometimes also result in an intrusive level of intervention -- particularly when applied inappropriately or when continued in behalf of people who have already reached the highest level of developmental progress they will attain under continuous training and supervision. Despite that drawback, the ICF/MR program is also the only one which provides a guarantee that the services a person needs will be provided. The rules mandate not only training but therapies, equipment and services necessary to achieve progress and compliance with all applicable rules.

On one hand, no other program gives providers this kind of leverage to access the services and equipment needed by the people served. However, even

with this statutory guarantee, the acquisition of services and equipment must often be negotiated with the state (sometimes through the courts in lawsuits filed under section 1902(a)(13)(A) of the Social Security Act, which requires that states develop reimbursement mechanisms that will permit "efficiently and economically operated facilities...to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards"). On the other hand, as long as the Medicaid program requires that each ICF/MR serve a minimum of four people with mental retardation and related conditions, and provide them with "active treatment... a protected residential setting, ongoing evaluation, planning, [and] 24-hour supervision," it will be difficult to use this program to optimize services and to support choices in the community. The charge that this program results in the "institutionalization of community services" is not unjustified when those served do not require the level of protection and services mandated in the statute and regulations.

HCB Waiver - Many people who do not require the intensive level of intervention provided in an ICF/MR are being well served by another Medicaid state option, the Section 1915(c) Waiver for Home and Community-based Services. The HCB Waiver program is often the best resource available to support people in a less restrictive setting. Tens of thousands of Americans with developmental disabilities are being served by this program and receive a diverse and often innovative array of services.

The HCB Waiver program is not without its drawbacks. A complicated formula restricts the number of people who can be served by a state, and another of the program's mandates presents state officials and providers alike with something of a dilemma. The HCB Waiver requires that people served be those who would otherwise require services provided in a Medicaid-certified ICF/MR or nursing facility. In the meantime, this program has greatly

facilitated the movement from restrictive larger settings to more integrated community living.

Community Supported Living Arrangement Program - The newer Medicaid program that supports the development of supported living arrangements in eight states is more flexible than the HCB Waiver program and is providing good insights into the ways community supports can be provided effectively. It encourages different approaches to individualized supports which promote choice and community involvement.

Fire Safety Codes - The loss of life in fires that have occurred in congregate living arrangements which did not meet even the most basic life-safety requirements has lead to the promulgation of increasingly restrictive requirements -- requirements that would not have been necessary if existing ones had been enforced. An analysis by the National Fire Protection Association (NFPA) of the boarding home fires that have occurred since 1979 reveals the absence of basic fire protection provisions in homes where deaths occurred. The deficiencies include inadequate means of egress, combustible interior finishes, unenclosed stairways and/or lack of emergency training for the people who lived in the homes. There have been very few multiple death fires (those that result in the deaths of three or more people) in board and care homes since 1985, when NFPA first published requirements for this type of residential occupancy, and none of these were in homes for people with developmental disabilities.

The 1991 edition of the NFPA's 101 Life Safety Code now requires that all newly developed "board and care homes," both those newly constructed and homes newly converted to board and care use, be equipped with an automatic sprinkler system. This requirement is applied to any "building or part thereof that is used for lodging and boarding of four or more residents, not related by blood or marriage to the owners or operators for the purpose of providing personal care

services." That definition clearly encompasses almost all congregate living arrangements in the community.

The Building Officials & Code Administrators International (BOCA) building code requirement is a bit different. It applies "institutional" fire safety standards to homes serving six or more people. This Code requires not only the installation of automatic sprinkler systems, but hoods over stoves and other costly construction features.

While the Health Care Financing Administration (HCFA) still applies the less stringent 1985 edition of the NFPA Life Safety Code to ICFs/MR, many individual states and jurisdictions apply the 1991 Code or the BOCA Code, inhibiting further development of housing for four or more people. Few will argue the benefit of automatic sprinkler systems to protect both life and property, but some people question the need for such a high level of protection that can be costly and hard to install, particularly when it does not appear that people with developmental disabilities are at great risk of dying in group home fires.

Providers have experienced difficulty finding companies that are interested in installing domestic or residential sprinkler systems in existing homes, and costs often far exceed estimates provided by the sprinkler manufacturers. The price is particularly high in rural areas where water storage must be provided.

In light of the fact that deaths are not occurring in small residences that comply with NFPA's less stringent 1985 Code, we suggest continued reliance on and enforcement of the 1985 edition of the Code, rather than adoption of NFPA's 1991 Code and others with sprinkler requirements that apply to housing for people who are capable of evacuating a home, with or without staff support.

Fair Housing Act - Zoning laws and special use permits that once were a problem for providers attempting to develop small living arrangements in local communities have largely been eradicated by the Fair Housing Act Amendments (FHAA) of 1988. That statute added people with disabilities to the classes of persons protected by Federal fair housing law. In the first case brought under the 1988 FHAA, construction of a home for 15 people was approved in Chicago Heights, Illinois.

The FHAA has also been used successfully to overturn local efforts to inappropriately apply fire-safety requirements to homes designed for people with disabilities who are able to demonstrate the ability to evacuate in times of emergency. In one case, the court agreed with a U.S. Department of Justice amicus brief that:

The City's reliance on outdated and unfounded stereotypes and prejudices about [people with developmental disabilities] rather than the particular needs of the individuals served deliberately [limit] the ability of the...women to live in the residence of their choice in the community. Such disparate treatment on the basis of handicap of those intending to reside in a home constitutes discrimination in violation of the [Fair Housing] Act.

The DOJ brief further states that: "It is not necessary to show that Defendant acted with 'evil intent' or animus against the disfavored group. Discrimination is forbidden by the Act, whether the motives underlying it are paternalistic or hostile." This last statement is particularly welcome by those who believe that people should be judged by their abilities first, and that they should not be treated differently from others in the population when with some support they can enjoy and participate in community life.

The Fair Housing Act significantly facilitates the establishment of community living arrangements.

Supportive Housing Program - Since the early 1970s the Department of Housing and Urban Development (HUD) has administered the Section 202 Direct Loan Program to develop small group living arrangements for people with disabilities. The National Affordable Housing Act of 1990 (NAHA) changed the name of that program and modified it so that it can be used to support a larger array of housing options in combination with needed supportive services. Under Section 511, the program of Supportive Housing for Persons with Disabilities authorizes assistance to private, nonprofit organizations in the form of capital advances, with additional operating funds available. The definition of "group home" is revised in the statute to limit development to housing for no more than eight persons with disabilities, but waivers may be obtained to permit the construction of homes for more people. No more than one home may be located at any single site, and no home may be located on a site contiguous to another site containing a group home. This statute also specifically approves the development of housing in condominiums, cooperatives and other multi-family projects.

This statute reflects Congressional values that promote small, integrated living arrangements for people with developmental disabilities and discourage the use of Federal funds to develop congregate living arrangements for more than eight people or on contiguous sites.

Labor Rules - The Fair Labor Standards Act (FLSA) protects American workers from exploitation. While Congress did not anticipate the need to address the treatment of employees who sleep on their employers' premises, the courts have handed down decisions that have guided the U.S. Department of Labor in establishing interpretations regarding sleep time requirements. These appear in the Code of Federal Regulations, Part 29, sections 785.22 and 785.23. While staffing in large institutions includes awake staff at night, in many small

group living arrangements employees agree not to be paid for up to eight hours a night of sleep time, provided that they are given a comfortable place to sleep and can usually enjoy an uninterrupted night's sleep. The smaller the living arrangement, the more likely that sleep will be uninterrupted because those who live in the home do not require attention during the night. At the same time, employees are present to assist in the event that an emergency occurs, and they are paid when sleep is interrupted and they respond to an emergency. The cost-effectiveness of hiring people who agree not to be paid for sleep time is obvious.

A Federal exemption from both minimum wage and overtime requirements is bringing costs down still further in some homes that are owned or leased directly by the people served or their families. When also permitted under state law, the Federal provision for people who provide "companionship services" can be used to provide some monetary compensation to people who agree to provide supports for a person with a disability, and to consider them employees who can receive benefits such as health insurance, vacation pay, sick leave and the like. While systems of voluntary support provided by neighbors are being established by some agencies, others are arranging to pay modest stipends, which are protected by this federal exemption, without risking a violation of the FLSA.

The statutory flexibility that is provided by the exemption for companionship services -- which can significantly reduce the cost of services -- helps promote small, individualized living arrangements in the community.

Internal Revenue Service - IRS requirements present different opportunities for developing innovative ways to obtain support for people living in the community. There are income exemptions for people who provide support in their own homes under special provisions for "foster care." These exemptions

encourage the establishment of homes for up to 10 children or five adults within a family home. However, when the oversight agency asserts more than minimal oversight of such living arrangements -- in order to assure that services are well provided -- the IRS income exemption and the very contractual nature of the home are threatened. If those providing foster services are identified as employees rather than contractors, they must be reimbursed on an hourly basis under the FLSA, subject to overtime and other Federal requirements, which makes this valued optional living arrangement economically unfeasible.

Americans with Disabilities Act - The Americans with Disabilities Act (ADA) was signed in July of 1990. It extends civil rights protections to people with disabilities that are similar to those provided to other individuals on the basis of race, sex, national origin and religion. It guarantees equal opportunity for people in employment, public accommodations, transportation, state and local government services and telecommunication; thus ensuring that people with disabilities will be able to access community services more readily and achieve greater self-dependence.

The statutes and regulations listed above are but a sample of those which affect the delivery of services and supports for people with disabilities. Ironically, many of these operate at cross purposes. On the one hand, they push the field in positive directions toward the development of individualized supports in the community for people with disabilities. On the other hand, the restrictive nature of some provisions inhibit and undermine provider efforts to meet the demands of Congress, state agencies and the consumers of services.

B. FUNDING REALITIES

States are facing increasing fiscal difficulties in addition to the problems at the Federal level with the national debt and budget deficits. Many states have frozen, if not reduced, funding for residential and other support

services. Some states have sought to control costs by eliminating or curtailing reimbursement for certain expenses like training, publications and association dues, thus reducing access to information and evolving state-of-the-art practices. Meanwhile, the costs of serving people continue to rise. State agencies, providers, advocates and the people served are now looking at the ICF/MR program in a new light, questioning the benefit of providing a program of continuous active treatment services (as currently defined by HCFA) throughout an individual's life. In addition, some of the people served are objecting to the rigid programs sometimes required to meet standards and are asking for greater control over their lives and relief from daily interventions. People everywhere are seeking less costly service alternatives.

States are trying to eliminate some of the full array of services identified in peoples' evaluations and individualized program plans, including staff support, various therapies, equipment, and dental care, in addition to some habilitative and medical services. The question is, which services can or should be eliminated? Some of those considered for elimination may be the most beneficial.

We fear that with the current Federal and state economic crises, services may eventually be limited to the bare essentials like room, meals and minimal oversight and training. While these supports may be adequate for some people; if we are not cautious we could again find ourselves talking about the "three hots and a cot" we used to associate just with institutional confinement. Care must be taken to assure that funding cuts do not result in the abandonment of people in unsupervised, unsupported community settings, or, worse yet, on the streets.

C. SUCCESSFUL EXPERIENCES:

Much of what we know about the success of small, individualized living arrangements is anecdotal. There has been some research, but our personal

beliefs are based on our own personal observations supported by the stories we hear about successful experiences. Most providers are too busy dealing with day-to-day requirements to collect data concerning the progress of the people they serve. Many of the individual success stories they share with us are remarkable and influence our attitudes.

There is a woman with both mental retardation and mental illness who lives in Maine, Edith Bralay, who spent 36 years of her life in state institutions, frequently in restraints because she made daily suicide attempts. She needed glasses, dental work and surgery to correct a deformity of one foot. She was also being catheterized every six hours. A member of NAPRR convinced the state to let her assume the risk and serve Ms. Bralay in a small ICF/MR for six people, even though it would mean taking her to the local hospital every six hours for the catheterization. Bralay was ready to agree to just about anything to get out of the terribly confining circumstances she had been placed in. She eventually agreed to leave a foley catheter in place while her bladder healed, she got glasses and dental services, had the orthopedic corrections she needed, and was treated with kindness and consideration. Her suicide attempts were rare and have not occurred in years.

Edith Bralay is now married and lives in the community with her husband Norman, where they get along primarily on Social Security, Supplemental Security Income and money from occasional jobs. They visit the agency offices from time to time and receive some drop-in services. It is hard to believe either was ever institutionalized. Rather than requiring more than \$124,000 per year each in institutional services, together they receive about \$20,000 in support annually. While their level of housekeeping might be criticized by some, there is no question about their decreased reliance on government funding or their increased self-dependence, community integration and personal satisfaction.

Change often occurs rapidly. The administrator of an ICF/MR for six people from a state institution who moved to his agency's community program, told us that when the state surveyors arrived for the initial certification survey, they recognized people they had observed while surveying the state institution. The surveyors were overwhelmed by the changes they were seeing in the appearances and behaviors exhibited by the adults who had moved to the home just two weeks earlier. The simple act of moving to an attractive small home with people who remained constant in their lives and who seemed to care about them had influenced dramatic changes. The people appeared and behaved in a remarkably more appropriate fashion after a very brief time in their new surroundings with almost no formal behavioral programming.

This is not to say that all experiences are as positive. We continue to hear about people -- with and without developmental disabilities -- who have been mugged, robbed or coerced out of their money, or raped by people they invited to come home with them. The proper balance of freedom with supervision has yet to be achieved for some, but we continue to hear far more positive stories than negative ones. The risk for each of us is relative to that experienced by others who live in the community around us. Additional regulation will not create a risk-free world! We all need to learn how to do our jobs and conduct ourselves in better ways to avoid injury or exploitation.

People with disabilities are not perfect, nor are providers, nor are institutions, nor is the community, but we believe that the disability system has come a long way toward a reliable level of oversight in the provision of high quality community services preferred by those who require supports.

D. PERSONAL PREFERENCES

Most important are the things we hear from people with developmental disabilities who live in small community homes. In large numbers they are

indicating that they are happier in less restrictive settings. They are demanding more control over their own lives. "Before, I existed; now I live!" stated one woman in a supported living arrangement.

Parents who once expressed a great deal of concern about the appropriateness of a community placement have also become convinced that their sons and daughters are doing better than anyone could have expected. The proper role for family members changes throughout a person's life. As with everything else in life, the answers will be different from individual to individual, and we must listen carefully to be certain that we correctly understand the wishes of the people served when parental involvement is considered.

The family home is not always the best place for either an adult or a child. Some people are exploited by their own families, some are even neglected and abused. On the other hand, many families are anxious to have their adult children with developmental disabilities move out of the family home. Alternative living arrangements must be available for people in either situation.

FURTHER AFFECTS OF RULES AND STANDARDS

We have heard that ours is the most highly regulated field in the nation -- more regulated than the nuclear power industry. The fact that this Subcommittee is examining oversight applied to our field and questioning its effectiveness is evidence that regulatory systems cannot guarantee quality. Many, many regulations are already in place but this Subcommittee is nevertheless expressing doubt about how well they work.

Several years ago, one of our members developed a list of entities that each year visit the residences he operates. He identified 13 separate organizations, including voluntary accrediting bodies and state and federal agencies which visited his homes at least once each year. Omitted from his

list is the Occupational Safety and Health Administration (OSHA). As we learned early last year, OSHA's Hazard Communication Standard applies even to small group living arrangements for a few people with disabilities if employees work there. It has resulted in citations for such things as:

- o Not having material safety data sheets (MSDSs) for the household products stored under the kitchen sink when OSHA believes they are used by employees more frequently than they would be used in a typical family home, and
- o The absence of an eyewash station in a small group home so that employees can simultaneously flush both eyes for 15 minutes in case hazardous materials such as Mr. Muscle Oven Cleaner or bleach should splash into someone's eye -- despite the fact that the same standard requires employees to wear goggles to protect the eyes when using products like these.

NAPRR is not convinced that standards of this nature are appropriate in small community living arrangements.

In 1992, OSHA's Bloodborne Pathogens Standard was promulgated and is also being implemented in ways that seem excessive in community living arrangements. To cite just a few examples of the enforcement of this standard, NAPRR members are being advised that:

- o Employees must wear gloves, gowns, masks and goggles when brushing the teeth of a person with a developmental disability (see Attachment C);
- o All sheets must be treated as though contaminated with blood, semen or vaginal fluid and placed in red bags or other marked containers and handled according to the standard -- even in homes where inspectors were assured that laundry was done by the users of the bed linens; and
- o All sanitary napkins, bandages, etc., stained with blood must be placed

in red bags or other marked containers and disposed of as hazardous waste in accordance with costly state disposal standards.

Compliance officers continue to issue this third citation despite the fact that OSHA has advised us that these materials do not require such disposal unless blood or semi-liquid fluid can be expressed from them when compressed. The inconsistency here is that, in fact, some bloodborne pathogens live in dried blood for a period of several weeks. On the one hand, if these products are dangerous, perhaps they should be disposed of as hazardous waste, with all of the procedures and expense that entails. On the other hand, why is this method of disposal not required for every public restroom and motel in the nation and considered a public health issue for private residences as well if it is required for small group living arrangements operated by agencies serving people with disabilities or who are aging?

In another unjust citation, providers have been cited and fined for not offering employees the expensive hepatitis B vaccine when they are at potential risk of exposure to blood and other body fluids because they assist people with tooth brushing or the provision of first aid, even though the vaccine was unavailable and they could demonstrate that it was on backorder. The new standard resulted in such a demand for the vaccine that it was quickly out of stock. It seems unreasonable that employers were fined when they had attempted to provide the vaccine to employees declared to be at risk of exposure to this disease, but had been unable to obtain it.

NAPRR members have appealed unreasonable citations and while fines have been reduced, to date none of the citations have been reversed, which implies that they are considered appropriate by OSHA officials. Our organization has written to OSHA and has met with them twice. While we have verbal promises that interpretations will be forthcoming, OSHA has not yet provided us with a written

response to our inquiries. We find no evidence of the transmission of hepatitis B from a person served to an employee in any group living arrangement operated by one of our members -- nor of transmission from one of the people living in a group home to another, despite the fact that these people engage in more risky behavior than that which occurs between employees and people served. Universal Precautions developed by the Centers for Disease Control and Prevention have successfully prevented transmission of bloodborne pathogens in the past and make us question the need for additional regulation.

Other national organizations have joined NAPRR in seeking meetings with OSHA officials to re-examine the bloodborne pathogen standard to see if it can be implemented in a more reasonable and logical manner. In September 1992, Senators William Cohen and Tom Harkin engaged in a colloquy urging OSHA to "look at the [bloodborne pathogen] standard as it applies to the field of developmental disabilities." Efforts to arrange such a review continue.

A recent decision by the U.S. Seventh Circuit Court of Appeals includes language which we believe supports NAPRR's concerns. The dissenting judge stated in his opinion that: "The rule can best be classified as an attempt to try to kill a fly with a sledgehammer...it was not drafted in response to an established significant risk of harm to employees...The rule unduly burdens health care employers...while offering but minimal benefit to their employees... Additionally, the rule duplicates the scientifically based and well-reasoned guidelines of the Centers for Disease Control and Prevention (CDC)." The judge suggests that the entire rule should be remanded to OSHA for reasons he details at length related to the need to:

- o Establish the significance of the risk,
- o Disaggregate industries when performing significant risk analysis,
- o Establish the significance of benefits,

- o Evaluate the focus which protects the employee but not the patient, and
- o Reexamine the feasibility of implementing the rule.

The judge, in his dissenting opinion, concludes that he fails to understand "why OSHA must assert authority over the health care field when it lacks the required medical knowledge, training, and experience, much less expertise. In the absence of proof that the CDC Guidelines are inadequate, any regulation by OSHA is unnecessarily duplicative of CDC efforts and merely serves to increase health care costs with little if any corresponding benefit." He urges Congress to take an "in-depth look at this problem to determine if OSHA should exercise its authority in the same realm as the CDC and the State health agencies."

The concurring judges also questioned the validity of OSHA's bloodborne pathogen standard. While deciding that the standard must be upheld as it pertains to the arguments heard in this case, these two judges agreed that this "is not to say that it is a good rule. It may be unnecessary; it may go too far; its costs may exceed its benefits."

Turning to another area of oversight, many NAPRR members are expressing increasing concern about the ability of a state's case management system to adequately function in this capacity, much less appropriately assess the quality of services. In several states, case management responsibility has been removed from the provider agency and placed with a state agency. State case loads are often so high that it is unreasonable for anyone to expect that the case manager can know the individuals for whom he or she is responsible. As just one example of the failure of some systems, we have heard of an instance where the case manager referred to the individual receiving services by the wrong name throughout an interdisciplinary team meeting. In addition, many case managers are assigned other responsibilities.

Without appropriate protections in place, state systems have not guaranteed

that appropriate case management services are being provided, and private providers are functioning in the capacity of a case manager without being reimbursed for this service.

There are obviously different opinions as to the effectiveness and appropriateness of rules and standards applied to residential services and supports for people with developmental disabilities. If the current level of oversight is inadequate, it is not clear that more would be better, nor that Federal regulation is any more effective than state or local quality assurance mechanisms.

Most current regulations are restrictive and are applied by surveyors in a punitive fashion. They tend to limit human potential rather than enhance it. Unnecessary attention to rules and regulations that do little to improve the quality of services can be a tremendous distraction from a provider's mission. Providers in the field of developmental disabilities are small business operators who physically cannot do everything they are currently required to do. Better management techniques include the concept of a "critical few things" which must be done in order to do a job well. Sometimes attention to regulatory detail results in the neglect of things that are more important in the delivery of human services. There are overwhelming demands on providers that require us to reexamine who the "customers" really are. They are not the funding sources or the regulators. The customers are the people who receive services. These are the people whose opinions must be sought to determine the critical elements of a service delivery system.

NEW APPROACHES TO REGULATORY OVERSIGHT

As this hearing is taking place, many efforts are under way to develop standards that more appropriately address quality of life issues. The Accreditation Council on Services for People with Disabilities and a number of

states are field testing or beginning to implement quality assurance systems that focus on personal choice and outcomes rather than paperwork and process.

Standards published by The Accreditation Council in earlier years have been considered for inclusion in statute at least twice since the early 1970s, and formed the basis for rules promulgated by the Health Care Financing Administration in 1974 and 1988 for intermediate care facilities for people with mental retardation (ICFs/MR). This reliance on The Accreditation Council's standards is evidence of the high level of public confidence in this body's quality assurance mechanisms.

"The Accreditation Council has shifted attention from assuring compliance with hundreds of processes to emphasizing a limited number of the most important outcomes for people," according to the introduction to their new standards now being field tested. "This field review edition of the Outcome Based Performance Measures is limited to 30 measures for people and 16 measures for the organization...This emphasis will enable an organization to clearly communicate that a limited number of variables account for the overwhelming outcomes in people's lives. A clear focus on a few variables will have a large payoff for people with disabilities," the Council believes. This realignment of the 628 standards that appear in The Accreditation Council's 1990 publication and system of accreditation is expected to contribute to the knowledge base of best practice for the '90s just as the Council's earlier editions have for the 1970s and '80s.

Last December, the National Association of State Mental Retardation Program Directors (NASMRPD) held a conference across the river in Alexandria, Virginia, that showcased more than a dozen quality initiatives that are being implemented in states around the nation. All of these have merit. Among them is a system now being applied on a voluntary basis in Oregon. Entitled

"Continuous Quality Improvement in Oregon's Programs for People with Developmental Disabilities," it is designed "to take the quality of services beyond the minimal requirements for staying in business and support people with disabilities so they could live and work in their communities with the same opportunities for a satisfying life as any other person. A second aim [is] to reduce state monitoring of local programs. A third aim [is] to coach and support programs through a process of self-monitoring based on surveys designed to assess the satisfaction of many key groups, the application of good management practices, and quality of life indicators." The "key groups" mentioned include families, employees and people who receive services -- all groups very frequently omitted from the survey process.

As Clarence J. Sundram, Chairman of the New York State Commission on Quality of Care has said: "We need to find a way to replace fear-based monitoring, citations of deficiencies, and plans of correction with more collegial, supportive and assisting means of improving conditions that affect the every day lives of the people being served. And in looking for ways to enhance quality for the people being served, we ought not to overlook the obvious and fail to ask them what they want."

Our nation's quality assurance activities have traditionally focused on standards designed to avoid abuse and neglect, but Sundram points out that they rarely address what he defines as "the systematic deprivation of autonomy and opportunity for greater self-direction, for a chance to live a life with meaning." But, he asks, "isn't this the essence of what quality is? This latter aspect poses a much more formidable challenge than dealing with incident reporting and similar QA activities," he states. The yardsticks Sundram believes we should rely upon for quality assurance are:

- o Comfort and personalization of the environment,

- o Living with persons of one's choice,
- o Spending time doing things that are meaningful and pleasurable,
- o Opportunities to learn,
- o The presence of informal supports by people who aren't paid, and
- o Opportunities to form relationships outside the circle of roommates and paid staff.

People with disabilities develop similar lists when asked what things are the most important in their lives. NAPRR agrees that these are the directions that must be taken in the oversight of human service programs. There must be health and safety standards which permit the right to reasonable risk, supplemented by standards that focus on personal choice and satisfaction and program outcomes.

Standards should also be in place to check the backgrounds of those who provide services. People convicted of fraud and abuse, or a history of indictments for such crimes, should not be permitted to manage community service agencies. In addition, those convicted or with a history of abuse or violence should not, without careful further investigation, provide direct support to people with disabilities. Unfortunately, the national reporting network is inadequate to identify all such people in a timely fashion, and many who should be screened out remain unidentified and involved in service delivery.

While our members generally prefer the implementation of Federal standards for ICFs/MR, it is impossible to revise these in a timely fashion as experience in the field modifies best practices. In addition, the paranoia that exists within state government over the potential failure of the state to appropriately implement the federal rules often leads to a state's promulgation of additional standards -- which are often excessive and even inappropriate -- to reinforce the federal system. Thus the State of Maine, for example, promulgated 131 pages

of state ICF/MR rules to supplement the 12 pages of Federal ICF/MR rules. In states like California, the Federal ICF/MR rules have been supplemented in a manner which significantly increases medically-related requirements, thus subverting the intention of the Federal rules to focus on developmental programming (in itself an outmoded service model) and outcomes of service delivery.

Quality assurance systems must change their focus to reflect the things espoused by experts like Clarence J. Sundram whose lives have been dedicated to assuring that people with developmental disabilities lead relatively happy and productive lives.

TAX STATUS, WAGES AND BENEFITS

NAPRR does not believe that the corporate status of a provider agency is an indicator of the quality of services. Whether not-for-profit, church related, for-profit or unincorporated family provider, the tax status can be used in both positive and negative ways to implement service delivery. The flexibility in the for-profit sector can lead to greater innovation and more immediate response to challenges, for example, than within a nonprofit agency whose board of directors intervenes in programmatic decisions or has conflicts of interest. Perhaps the least flexible system is the public sector where innovation and program responsiveness may be the most inhibited and where conflicts of interest arise when the State is guardian, representative payee, case manager, interdisciplinary team coordinator, payor, advocate and provider of services.

Salaries and benefits vary tremendously at all levels of employment from state to state and even within a state. Unfortunately, it is often at the bottom of the rung where the disparity between public and private sector wages and benefits vary the most. As data collected and analyzed by the University of

- o The mean starting wage for direct service employees in privately-operated community facilities in the U.S. was approximately 24% less than the wage for similar employees in public institutions;
- o The disparity in starting wages between privately-operated community and institutional direct service employees has grown larger during the last decade; and
- o Fringe benefits for direct service employees in privately-operated community facilities were offered substantially less frequently than benefits for similar workers in public institutions.

The report, Residential Services and Developmental Disabilities in the United States, concludes that the "compensation of direct care workers remains a serious national problem."

At the upper levels of administration, we find that a higher salary is appropriate for the administrator of an agency that provides a variety of good quality services to two or three hundred people, but would not be in an agency serving a few people poorly. There are also highly-paid administrators who work 60 or more hours per week, whose hourly rate of pay may actually be quite low, but if another administrator can demonstrate the ability to offer services of a high quality for the same cost when working fewer hours, then salary or benefit levels should not be a consideration. One would have to question high salaries paid to administrators of agencies that are providing poor services and who pay support staff minimum wages and few benefits. No citizen can adequately support him- or herself, much less a family, on today's minimum wage. Reimbursement systems must be adequate to pay people a living wage and to provide good benefits and adequate training.

The factors which seem to influence the quality of services the most are the least tangible: the values of the people in leadership positions and their

true level of commitment to their employees and the people who receive supports. There are agency leaders who have a knack for hiring people of principle and who instill their own values in their employees at every level. Others, who may be less inspiring, are good managers whose programs offer a far higher quality of life to those who receive supports than the most well-intentioned do-gooder who cannot grasp the complex system of service delivery and who inhibit rather than expand human development.

Consumer satisfaction and outcomes rather than tax status -- and an understanding that no single entity can please all of the people all of the time -- should regulate the purchase of services. If agencies are encouraged to develop, and consumers are given clear choices among which to select a provider of services and supports, those who are performing inadequately will cease to exist and those who are doing the job well will expand, whether public, private, church-related, non-profit, for-profit or unincorporated family or personal assistance service provider. It should be up to the individuals who need supports to decide from whom to purchase services. We believe that multi-home, multi-service and multi-state agencies have demonstrated that they can provide services that equal or even exceed those offered by some agencies that operate only one home or a single type of service.

CONCLUSIONS

In summary, the service delivery system is not static. Change must be encouraged as must the development of a free enterprise system where the customers are offered a variety of options and real choices from which to select the supports that provide the greatest benefit and highest level of satisfaction in a cost-effective manner. There is no single best solution for all people. It is overly simplistic to think that one's own way is the only acceptable way, or that there is one solution to all problems. Human beings have not yet agreed

which is the most appropriate way to worship God, though many are certain that their way is the only acceptable one. The view of service delivery is often seen in the same way. There is no single right way for everyone.

Let us recognize the value in differences. We select mates, friends, homes, automobiles, everything in our lives on the basis of our personal preferences. Clearly, what is suitable for one may be totally unsuitable for another. Services systems must recognize that it is the same in human services. Diversity should be valued and human potential must be acknowledged. Wherever possible, individual preferences must drive the system.

The way we frame issues determines how we identify problems; and the way we identify problems determines the solutions sought. Therefore, it is critical that problems encountered in providing supports and services within the community be correctly defined to ensure that valid means will be identified to resolve these problems. NAPRR stands ready to assist this Subcommittee and other members of Congress in correctly identifying problems in the community that are barriers to the growth, health and safety of persons with mental retardation and other developmental disabilities, and to seek beneficial solutions.

Thank you for giving us this opportunity to express our concerns about the system as it exists today. We look forward to working together to continue to improve the lives of people with developmental disabilities.

National Association of Private Residential Resources

Serving People with Mental Retardation and Other Developmental Disabilities



Guiding Principles

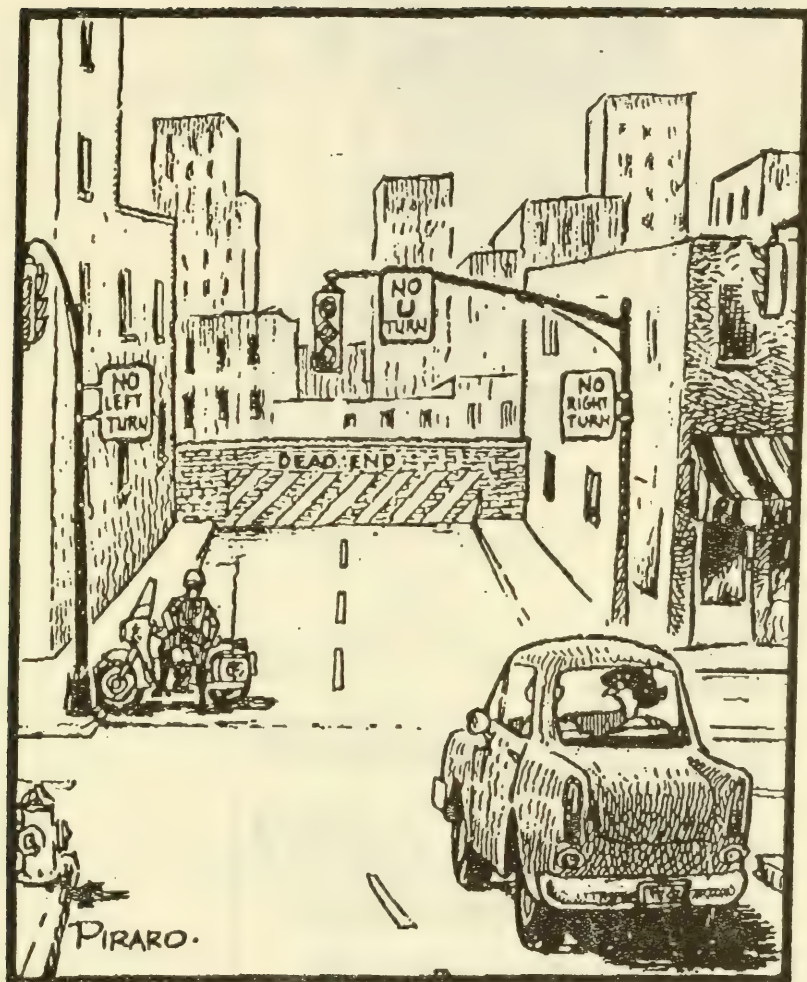
The National Association of Private Residential Resources (NAPRR) establishes the following guiding principles for providing services and support to people with mental retardation and/or other developmental disabilities.

We who offer services and support to people recognize:

- That each individual should be offered opportunities to enhance and increase informed decision-making throughout a spectrum of expanding and continuing choices concerning:
 - where one lives,
 - services one receives
 - with whom one associates
 - enrichment opportunities in which one participates;
- That each individual is provided with the opportunity for self-direction;
- That each individual is entitled to the full range of constitutional freedoms, including autonomy, dignity and the right to privacy and to representation; and
- That as each individual changes, efforts are made to promote meaningful, ongoing participation by the individual in his or her life planning process.

We who offer services and support to people further recognize:

- That our role has evolved to one of cooperation, mediation and facilitation;
- That our role in promoting full participation involves a reciprocal people-centered approach of respect and sensitivity for those involved;
- That we face greater responsibility in mediating and moderating balance among individual choices and vulnerabilities;
- That we accept the shared responsibility in making affirmative efforts to advocate for systems change and gain necessary resources to benefit people;
- That we expect an ethical and legal commitment from funding sources to assure necessary and sufficient support; and
- That we promote an optimal quality of life to increase:
 - self-dependence,
 - productivity,





Brushing up

Lisa Cornwell, an apartment coordinator at the Harry Meyerling Center, displays the equipment staff members now have to wear while helping mentally retarded residents with their daily needs.

Astronaut care?

Director: New rules put dents in dignity

By JOE TOUGAS
Free Press Staff Writer

MANKATO — How would you feel if the person helping you take care of yourself at home one day showed up wearing a plastic mask, rubber gloves and an apron?

"That I'm less than whole, that I'm not a healthy person," figures Carol Lee, director of the Harry Meyerling Center

were carrying blood disease.

And in homes such as HMC, where the staff philosophy is to foster an atmosphere of normalcy, the new measures amount to needless overkill, Lee said. And, she continued, part of the cost of following the new standard is residents' dignity.

The new standards, established by the Occupational Safety and Health Administra-

STATEMENT OF TESTIMONY

on

**The Regulation of Community Residential
Services for Individuals with Developmental Disabilities**

Respectfully Submitted

to the

**Subcommittee on Regulations, Business
Opportunities and Technology**

House Committee on Small Business

The Honorable Ron Wyden, Chairman

Presented by

**Toni Richardson
Commissioner, Connecticut Department of
Mental Retardation**

speaking on behalf of the

**National Association of State Mental
Retardation Program Directors, Inc.**

March 29, 1993

My name is Toni Richardson. I am the Commissioner of the Connecticut Department of Mental Retardation. I appear before you today as a spokesperson for the National Association of State Mental Retardation Program Directors. NASMRPD is an organization comprised of the chief state mental retardation/developmental disabilities official in each of the fifty states and the District of Columbia. Collectively, our member agencies furnish a wide variety of services and supports to roughly 500,000 citizens with mental retardation and other developmental disabilities, nearly 300,000 of whom receive residential services through programs we directly operate or finance.

We are pleased to appear before the Subcommittee today to discuss the topic of state oversight and management of community residential programs for people with mental retardation and other developmental disabilities. This is an enormously important topic and one that I and my colleagues in other states wrestle with every day.

Over the past decade, there has been an historic shift in state systems for serving people with developmental disabilities. We have moved from service systems dominated by large public institutions and other congregate care facilities to one in which community-centered services have become the rule, not the exception. People with developmental disabilities now receive services and supports in a diverse array of community living arrangements. By the end of 1993, the number of people residing in large publicly-operated residential facilities will have declined to roughly 71,000, nationwide. Fifteen years ago, twice as many people were served in these facilities. Roughly 20,000 institutional beds will have closed since 1988.

This reduction in institutional services has been more than offset by the increased number of people served in various types of community living arrangements. Approximately three out of every four individuals who receive state-funded residential services now are served outside state institutions. Usually, these living arrangements house 15 or fewer individuals. In recent years, the national trend has been to develop smaller living arrangements, so that in many states today the typical community residence serves eight or fewer persons. Furthermore, more and more states are sponsoring the development of supported living programs, where services and supports are furnished in consumer-controlled, regular housing stock in which one, two or, at most, three individuals might choose to live.

In short, we have witnessed a major shift from large, publicly-operated congregate care facilities to a more diverse and decentralized array of community-based residential services and supports for people with developmental disabilities. This shift has been facilitated enormously by the availability of federal matching dollars through the Medicaid home and

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community-based waiver authority. The waiver program has allowed the states to secure Medicaid financing to pay for a more agile and diverse array of community services. Dollars that previously were locked up in institutional settings can now support people more flexibly in their own communities. This year, the states expect to serve 98,000 people with developmental disabilities through their home and community-based waiver programs.

The changes which have occurred -- and are still occurring -- in state developmental disabilities service delivery systems have been enormously beneficial. People are better off living and working in the community. Their lives are richer and their choices are wider. Certainly, the available research confirms that people do better in community settings than in institutions. Hopefully, we have passed the point of wrestling with the question of whether people with developmental disabilities can or should live in their own communities. The answer is that, of course, they should. Disability should not and must not result in segregation and isolation.

Having made that point, the question is how do we ensure that the rights and well-being of people with developmental disabilities are protected in the community? Privatization, diversification, and decentralization of service delivery has had many positive benefits for people with developmental disabilities. We would not have been able to accomplish what we have over the past decade without the public-private partnership which has emerged as a major feature of service delivery policy. Our service systems draw enormous strength from the efforts of literally thousands of non-profit organizations across the country. They form the backbone of state community service delivery systems.

At the same time, the reconfiguration of developmental disabilities service delivery systems has confronted the states with daunting challenges related to the management and overseeing of diverse service delivery networks. Assuring that people receive high quality services and are free from abuse, neglect, or exploitation within these networks is, by any measure, a major undertaking. Neither I nor any of my colleagues in other states have found the magic answer to meeting this challenge, but we are striving to address this issue.

At a very basic level, the outcomes we are attempting to achieve for people with developmental disabilities are easy to articulate: (a) they should receive the individualized supports necessary to live successfully in their communities; (b) the services and supports they receive should be effective and efficient; (c) they should have a strong say in how services and supports are furnished; and, (d) their rights should be respected and they should be protected from abuse, neglect and exploitation. Translating these outcome goals into day-to-day practice, however, involves striking a balance between frequently competing objectives. We know that, if we are overly protective, the result will be similar to

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the oft-criticized problems which have arisen in the delivery of health care services: practicing "defensive medicine" that subverts the very outcomes we are trying to achieve, in addition to breeding an environment of systemwide mistrust. We also know that, if we are too protective, we can end up denying people opportunities to make decisions for themselves or participate in the mainstream life of the communities in which they live. Yet, we cannot forget that people with severe cognitive and physical disabilities are often highly vulnerable. This vulnerability requires special vigilance at all levels of the state/local service delivery systems.

As systemwide managers, we know that the reliability and ultimate effectiveness of community developmental disabilities services is tied to three closely related variables:

- The agencies and personnel who support people with developmental disabilities must be competent and motivated to achieve high quality. Unless an environment conducive to high quality performance is maintained at the agency and staff level, we will not have effective services.
- Affording people with developmental disabilities adequate protections involves some degree of traditional regulatory oversight. At the same time, there is no system of inspection yet devised which, by itself, will yield the kinds of results that can be achieved when family members, people with developmental disabilities, and other interested citizens are actively and continuously involved in the process of service delivery.
- Problems that arise must be dealt with swiftly and decisively by the responsible oversight agency.

Piling regulatory mandates on top of one another and dispatching state survey teams to inspect programs are clumsy and limited tools for achieving the outcomes we desire. In many ways, state DD service delivery systems currently rely too heavily on such traditional regulatory models. Service providers tell us routinely that achieving regulatory compliance breeds an atmosphere of mistrust while standing in the way of achieving excellence. On-site inspections and some level of government regulation are a necessary part of any well-rounded approach to quality assurance. However, it would be a serious mistake to conclude that the answer to existing program deficiencies is to hire more surveyors and create even more detailed operating rules.

In Connecticut (as in a growing number of other states), we have sought to address the challenges involved in overseeing an increasingly far-flung service

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delivery network in a variety of ways. Roughly one-third of our central office staff is assigned to quality assurance. We operate a fairly elaborate "flagging system" that tracks service delivery problems as they arise and monitors the follow-up actions needed to correct such problems. This system helps us to spot problems before they become major crises. Our regional offices are staffed with case managers who regularly visit people receiving services. We have tough standards that private providers must meet. We invest a considerable amount of money in training our own staff as well as personnel employed by community provider agency.

We also have attempted to move beyond the traditional regulatory apparatus and into positive strategies to improve quality. One of our most exciting initiatives is our Service Enhancement and Quality Review Process, where we assemble teams comprised of volunteers with different skills and personal perspectives to conduct two-day, on-site reviews of community programs. These volunteers include family members, people with mental retardation, other individuals drawn from the community at large, and personnel from other service agencies. We train these volunteers. The site reviews conducted by such quality teams give the provider agency and my Department an enormous amount of valuable feedback concerning the ways in which services can be improved. This process has yielded results which never could have been achieved through traditional regulatory methods. As a result of these reviews, we are seeing real improvements in the quality of our service programs as well as better involvement of family members and people with mental retardation in the decisionmaking process. The quality review teams succeed because they discover better ways of serving and supporting people with developmental disabilities.

Are we satisfied that we have solved the quality equation? No. Do we believe we are making real progress? Yes. Can we do better? Yes.

Before turning to the Subcommittee's specific questions, I would like to offer several perspectives and suggestions that might help frame many of the issues involved. First, as state program administrators, we take very seriously our responsibility to provide adequate protections for people with developmental disabilities who are receiving state-funded community residential services. As we have come to rely more heavily on Medicaid financing of our community service systems, we do not take lightly the health and safety assurances that we must make as a condition of receiving federal dollars under the Medicaid home and community-based waiver program. The federal waiver authority affords us considerable flexibility in determining the best means of meeting this assurance; but it does not -- nor should it -- give us the latitude to overlook instances where the well-being of consumers are threatened.

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Second, the fact that problems arise in the day-to-day delivery of services to people in community residences should not overshadow the fact that such services, by and large, have been enormously successful in meeting the needs of people with developmental disabilities. Community-based services have opened up new vistas for tens of thousands of such individuals. It should be pointed out that many of the most exemplary community-residential programs in this country have been made possible by Medicaid home and community-based waiver financing. Thousands of people with developmental disabilities have left institutions as a result of this program and are leading far more satisfactory lives as a result.

Third, on numerous occasions over the past few years, our Association has proposed changes in federal policy that we believe would lead to a stronger federal-state partnership in promoting high quality, reliable community services for people with developmental disabilities. Certainly, one element of such a partnership involves an improved delineation of the minimum protections that must be afforded to people with developmental disabilities. While there can and should be legitimate debate concerning the content of the enforcement mechanisms needed to achieve such protections, we believe that people with developmental disabilities and their families have every right to expect that basic protections will be in place and assiduously enforced.

Beyond the question of these basic protections, however, the federal-state partnership must be reframed along more constructive lines. In the past, the debate too often has been limited to the types of federal regulatory requirements that should be imposed as a condition of additional federal support for community-based services, rather than discussing as well proactive strategies for improving the quality of the services that are furnished. When Congress authorized the optional coverage of "community supported living arrangements" (CSLA) services under state Medicaid programs in 1990, we believe some positive steps were taken along those lines. The legislation introduced concepts such as independent monitoring boards and the development and public debate of multi-faceted quality assurance plans. These were steps in the right direction. The basic approach should to quality assurance contained in the CSLA legislation should be refined and the remaining problems worked out. The key strength of this approach is that it insists that a wide range of key system actors -- including family members and people with developmental disabilities -- play an active role in the quality assurance/enhancement process. Certainly, our experience in Connecticut attests to the positive outcomes of this approach.

Fourth, we all need to recognize that achieving quality in community services will necessitate the investment of additional public dollars. These days state MR/DD agencies are struggling to hold onto the financial resources they have. In nearly every state, including Connecticut, we confront terrible trade-offs between

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additional investments in service quality that we know we should be making versus meeting the needs of unserved individuals. In the severely constrained budget environment we live in today, setting aside additional funds to improve the quality and reliability of existing services, unfortunately, means that some people will remain unserved who otherwise might have qualified for assistance.

Certainly, we are keenly aware that we can hire better community workers if we are able to pay higher wages. It also is clear that we can make better and more effective use of our resources if we invest more dollars in training and technical assistance. At the same time, requests for such funds compete with a host of other legitimate state budgetary priorities. Over the past two years, the central office staff of my agency in Connecticut has been reduced by 40 percent.

One of our problems is that the state dollars which have been invested in promoting quality assurance/enhancement activities are not matched by the federal government. In the home and community-based waiver program, very few federal dollars are available for quality improvement activities. On the other hand, the federal government expends large sums of money to pay for survey and certification of institutional settings (including ICF/MR-certified facilities). Certainly, one piece of improving the federal-state partnership in this area should be a more equitable sharing of the financial responsibilities for community quality assurance and enhancement activities. One step that could yield very positive results would be for the federal government to make specially earmarked grants to the states to fund quality improvement initiatives -- rather than tying such funding to the convoluted system of reimbursing states for Medicaid administrative expenses. The establishment of a targeted grant program of this type would signal a willingness on the part of the federal government to invest in quality, not simply to demand or mandate it.

Turning to the specific questions raised in the Subcommittee's March 5 letter to the Association, we would offer the following responses:

1. Where do the providers of MR/DD community based housing come from? Who operates these homes, how are employees trained and how are the services provided financed?

In the majority of cases, the providers of community residential services are non-profit agencies, formed on a voluntary basis and overseen by boards of directors that typically include a cross-section of local citizens, family members, and, increasingly, people with developmental disabilities. In many cases, these agencies were started by parents and other concerned citizens in response to the dearth of local services. While reliable statistics are not presently available, only a relatively small share of existing services are furnished by proprietary organizations. In a limited number of states (including Connecticut), state MR/DD agencies directly operate community residences. A reasonable

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nationwide estimate is that 5 percent of all community residences are state-operated.

The employees of community MR/DD agencies are a mixture of degreed professionals and individuals who possess certain minimum qualifications but basically acquire their job skills through a combination of formal and on-the-job training. In nearly every state (as well as according to the policies of many community agencies), workers must receive some level of initial training, go through a period of supervised on-the-job training, and attend periodic refresher courses.

Community residential services are financed through a combination of funding sources. In the Medicaid home and community-based waiver program, residents are expected to contribute a portion of their income toward meeting the costs of room and board. The remaining costs are typically reimbursed through federal-state Medicaid payments. Other community residences are financed through resident room and board payments and state-only grants or contractual payments. In the case of a residence which is certified as an ICF/MR, all costs, including room and board charges, are financed through federal-state Medicaid payments. With the exception of the residents' contributions (which often consist of their SSI benefits, minus a personal needs allowance), community residential services are funded largely through public dollars, although in some instances non-profit agencies also contribute dollars to cover uncompensated costs.

2. Is the role of multi-state provider chains growing? Does over reliance on any one provider present a problem to state directors -- for example, does over reliance on a single provider hamper the ability to eliminate poor performers from the market?

To our knowledge, there are no available national statistics concerning the relative role of multi-state provider agencies. As a general matter, the role of these agencies probably has expanded over recent years, although there is a good deal of variation from state-to-state.

The issue of over reliance on particular provider agencies is complex. In nearly every state, there is a shortage of provider agencies willing to develop new services. In many states, the service provider network has not been expanding; instead, the number of separate residential sites operated by existing providers has been growing, in some cases quite rapidly. In more rural areas, it is not uncommon to find only one residential service provider. Operating with a short supply of provider agencies does pose regulatory dilemmas -- in particular -- a reluctance to decertify an agency except as a last resort.

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Clearly, there would be many benefits to expanding the supply of qualified providers. Certainly, if the role of proprietary agencies has been growing, one reason is that such agencies have better access to start-up capital than most non-profit organizations. In order to expand the number of provider agencies, at least three steps would be necessary: (a) provide increased funding to meet start-up costs for new organizations; (b) change federal Medicaid policies so that they permit start-up costs to be recovered more quickly; and, (c) increase vacancy rates by paying more per capita to cover the additional costs of maintaining such vacancies. In other words, expansion in a state's provider network could be achieved but probably only by increasing systemwide service costs.

3. How can oversight and quality control in community based MR/DD housing be improved and enhanced without further burdening state agencies with additional regulations and mandates?

First, there is no stronger means of improving oversight than to have the active involvement of family members, people with developmental disabilities, and other citizen volunteers who routinely visit and stay involved in the operations of community residences. Whether in conjunction with more formal community monitoring teams or as a matter of policy, the best type of oversight program is one that is locally-based and engages community members in the affairs of the residence.

State and federal policies in this area need to be restructured. They are anchored too firmly in an institutional regulatory model. We know that this model has very limited utility when superimposed on community programs. Clearly, the answer does not lie in adding more regulations or mandates. The general quality assurance/enhancement requirements contained in the Community Supported Living Arrangements legislation provides a useful starting point.

The fundamental structure of Medicaid law and regulations also needs to be reworked to foster a greater role for consumers, family members, and local service authorities in assuring quality and promoting local involvement in decisionmaking. Finally, instead of more proscriptive policies, we believe that strategies for assuring the individual health and well-being of every consumer must be built into each person's service plan and assiduously monitored at all levels.

Third, an improved federal-state partnership in promoting high quality services is needed. We believe this objective can be accomplished without adding to an already ponderous list of regulatory mandates. We would hope that the Subcommittee would entertain more specific proposals in this regard.

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4. As the provision of MR/DD services is increasingly decentralized and localized and large state facilities are replaced with community-based group living facilities, how are the burdens of oversight heightened?

Undoubtedly, the shift from large congregate care facilities to small, widely-dispersed community residential sites increases the time and resources required to monitor program quality. For example, it takes roughly two days to conduct an on-site review of a group home and at least as much or more time off-site to prepare for the review and conduct follow-up activities. This means that a review team can visit anywhere from 40-50 facilities a year, at most. Closing a 300-bed state facility (where reviews might consume anywhere from two-three weeks annually) can spawn anywhere from 40-60 new residential sites. In pure workload terms, then the oversight burden can increase by a factor of ten or more.

States attempt to cope with their expanded oversight responsibilities by monitoring the operations of agencies in a variety of ways. One way is to conduct sample reviews. For example, if an agency operates several sites, only a few might be selected for intense review; if problems are encountered at these sites, the review is widened. The second way of addressing these expanded responsibilities lies in empowering case managers to conduct regular monitoring visits to all provider agencies falling within their respective caseloads.

5. Have methods and processes for quality assurance in small group living facilities kept pace with the growth of this industry?

In many respects, the answer is yes, with some important caveats. State monitoring procedures, as a general rule, are getting better; they are more effective and sophisticated. Nonetheless, in these difficult budgetary times, resources for quality assurance activities are in short-supply. We need to be doing more follow-up on corrective action plans. Financial auditing is another area where most states would agree more attention needs to be paid.

7. What steps have state directors taken to ensure that personnel working in MR/DD community housing are appropriately trained and free of abusive or criminal histories? Have these efforts been effective?

As indicated earlier, it is common practice in the states to establish minimum qualifications for community workers and require that such workers possess or acquire certain basic competencies. Many states also have enacted laws mandating that community workers be subject to pre-employment background checks.

State experience in both of these areas has been mixed. While criminal background checks are becoming more or less routine, there is no where near

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the level of reporting and information available concerning histories of abusive behaviors in adult services as there is through state child abuse and protective services networks. This is changing as more and more states beef up their basic adult protective services statutes.

Training is another area where the states' experiences are mixed. A good deal of training is furnished by provider agencies. As a condition of participation, states routinely check that mandated training has occurred. The states, however, are hard-pressed to augment this training in a consistent, routine fashion with other training opportunities. Only a limited number of states have developed and implemented standardized, systemwide training curricula.

8. Are workers in these facilities adequately compensated and provided with sufficient benefits?

In general, the answer is no. Turnover rates are high. Wage and benefit studies continually reveal that community worker compensation falls into the range of employees of fast food establishments. In some states, this situation has prompted legislatures to earmark special funds to improve community worker wages. This occurred in Connecticut during decidedly better economic times. As budget allowances shrink, it is extremely difficult to hold onto such special salary enhancement funds. Again, given a choice between the continuation of services to existing clients and raising employee salaries, legislative bodies, understandably, usually opt for the former. We do know that better compensation would stabilize the work force and improve quality. The question is: how do we obtain the funds to pursue such initiatives in the present budgetary environment in most states.

9. What is the appropriate role of parents and family in the planning and implementation of programming for MR/DD populations?

Parents and other family members have vital roles to play in service planning and implementation. Actively involved parents and family members can tell us quite a lot about the range of supports that would best meet the needs of a person with a developmental disability. Our experience in Connecticut has been that the more family involvement, the better. In family support programs across the country, parents increasingly are being relied upon not only for input but also to actively manage services and supports for their sons and daughters.

At the same time, an expanded role for family members must be balanced off against the right of emancipated adults with disabilities to make decisions for themselves. Indeed, one of our benchmarks for success is the extent to which service consumers are making choices for themselves. Conflicts do arise, just as they do in any family. Parents and family members have disagreements with service providers and other professionals. That is why we plan and implement

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services through teams that include the individual to be served, involved family members, and professionals. In nearly all cases, the team process resolves such conflicts. When it does not, states have grievance and appeals procedures for resolving such differences.

* * * * *

I would like to thank the Subcommittee for this opportunity to appear and discuss this important topic. Let me assure you, once again, that NASMRPD shares with the Subcommittee the aim of affording all people who receive services in publicly-financed community residences both adequate protections and high quality services.



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STATEMENT OF

ELIZABETH JONES
EXECUTIVE DIRECTOR

MARYLAND DISABILITY LAW CENTER

ON BEHALF OF

**THE NATIONAL ASSOCIATION OF
 PROTECTION AND ADVOCACY SYSTEMS, INC.**

BEFORE

**THE SUBCOMMITTEE ON
 REGULATION, BUSINESS OPPORTUNITIES AND TECHNOLOGY**

THE HON. RON WYDEN
CHAIRMAN

MARCH 29, 1993

Chairman Wyden and Members of the Committee:

My name is Elizabeth Jones and I am the Executive Director of the Maryland Disability Law Center, and a member of the Board of Directors of the National Association of Protection and Advocacy Systems. I am pleased that you have given NAPAS the opportunity to participate in these critical hearings on small group and community-based housing for people with mental retardation and developmental disabilities.

For the past three years, I have served in the capacity of Executive Director of the Maryland Disability Law Center, the agency designated as the Protection and Advocacy System for the State of Maryland. I have over 20 years experience in issues relating to people with mental retardation and developmental disabilities, specifically with care and housing issues. For two years I served as the Acting Superintendent for the Belchertown State School, an institution for people with mental retardation in Massachusetts; for three years I was the District Manager in Western Massachusetts for the State Department of Mental Health, overseeing all aspects of mental health and mental retardation services in that part of the state; and for four years, I was the Coordinator of the Dixon Implementation Monitoring Committee overseeing mental health services in the District of Columbia.

NAPAS is a national voluntary-membership organization representing the protection and advocacy agencies for developmental disabilities and mental illness and Client Assistance Program for people with disabilities. Our system has been established under a variety of

Public Laws, including the Developmental Disabilities Assistance and Bill of Rights Act of 1975 (P.L. 94-103), the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (P.L. 99-319), and the 1984 Amendments to the Rehabilitation Act (P.L. 98-221). Our membership provides legal, administrative and other means of redress for individuals with disabilities. Congress has mandated as one of the missions of our membership to investigate charges of abuse and neglect in institutions, both public and private, large and small, which provide housing and services for people with mental retardation and developmental disabilities. We recognize the need for advocacy and monitoring of all facilities serving individuals with disabilities, however, due to limited resources, not all P&As are able to work in smaller, community living arrangements and must concentrate on the larger public institutions.

As advocates, we have learned important lessons as States have changed from primarily an institutional system to one that is community-based. Although litigation has been a major catalyst for such change, it is not the only factor. There have been remarkable advances in our knowledge about habilitation and the ways in which people with a developmental disability learn new skills. We know that learning is most likely to occur when there are positive role models, individualized teaching practices, flexible supports, adequate resources and high expectations. Research studies indicate that small community-based programs are more likely to provide this type of environment and to be more cost effective in spending scarce dollars. It is also critical to note that thousands of people with disabilities and their families have forcefully expressed their desires to live in ordinary neighborhoods. Quite

candidly, there are instances of community programs that do not offer a safe and supported environment. There may have been inadequate planning or staff training; funding may be inadequate to meet the needs of the clients; program practices may be restrictive or punitive. Significant work remains to be done if the community-based system is to be truly responsive and responsible. For example:

- Individualized planning, rather than a cookie-cutter approach, must be the basis for designing and delivering housing and other supports to people with a developmental disability. There must be a clear focus on what the client wants and requires rather than a simple reliance on what the provider has to offer. There must be a more meaningful effort to have the individual with the disability participate in the planning process rather than continuing to rely on professionals and other staff to make the decisions alone.

- Resources must shift from the institution to the community system. Community services have not received adequate funding and have been forced to provide services with poorly paid staff, troublesome cash flow problems due to late payments, and significant cutbacks in these times of fiscal austerity. Although the census at institutions continues to decrease, costs continue to rise and the funding does not adequately follow the client into the community.

- The approach to providing housing and other support services requires radical

redefinition. There must be increased involvement and funding of natural support systems and greater reliance on strengthening generic services rather than creating specialized services for people with disabilities only. The new Community Supported Living Arrangement (CSLA) programs funded by the federal government are an excellent step in this direction.

* Additionally, independent advocacy must be seen as an essential component in the design and implementation of community services. We believe that resources for advocacy should be as important a part of the equation as case management or other supports. In fact, some consent decrees now in effect contain language requiring advocacy services to be funded as part of this decision. For example, the North Dakota Protection and Advocacy system was vested by the court with an advocacy program for persons with mental retardation. Under this consent decree in *The Arc North Dakota, et al v. Olson, et al*, (Civil No. A1-80-141, attached), the court mandated that sufficient funds were to be allocated to hire and maintain qualified personnel, and to provide for their training, travel and supplies. We see this as an important step in recognizing that advocacy programs must receive adequate funding.

I'd like to spend a few moments discussing what the P&As have been doing with the funding they receive. I hope this will serve as an illustration of why advocacy on behalf of individuals in group settings is so crucial, and effective. As the Director of the Maryland program, naturally I'd like to turn to my state first.

Since 1985, the Maryland Disability Law Center has been involved in litigation focused on the development of a comprehensive quality assurance system in Maryland. Our lawsuit, *MDLC v. Sabatini*, seeks to compel the State to develop procedures that monitor both community and institutional programs on a regular basis; investigate allegations of abuse and neglect; require training of direct care and supervisory staff; and take corrective action as appropriate. As we have learned more about the criteria for an adequate quality assurance system, we have broadened the focus of our relief. We are insisting that the State demonstrate its commitment to the provision of quality services by implementing a more thorough and objective review of suspicious deaths; providing technical assistance; establishing sanctions and other procedures to eliminate poor management and program practices; and, very importantly, by providing a system of incentives to acknowledge and reward positive practices.

In order to monitor the complaints we receive about both institutional and community programs, MDLC has developed a data system that tracks allegations by client, program, type of harm, and corrective action. We will use this information to educate state administrators, legislators, and the general public. We may pursue our own investigations of these complaints and either file legal action on behalf of the individual client or refer the client to a *pro bono* attorney. We have sought, and won, damage actions on behalf of clients who have been injured through neglect and malicious abuse. We routinely visit community and institutional programs in order to observe what is happening to clients. It is clear that the individuals who are at most risk are those who are unable to speak for themselves or

request our assistance directly.

Additionally, we have recruited and trained attorneys in private practice, including prestigious firms, to represent people with a developmental disability in order to increase the visibility given to these cases in our local cities and towns.

Florida has had a community monitoring program up and running for only one year, but already is meeting with success. As you will see in the following examples, it is often the simple solutions that offer the most rewards for individuals. The first example is the case of a 22 year old man who uses a wheel-chair and is unable to communicate verbally, residing in a six-person group home. The advocate found him quite pleasant, alert, and with a strong desire to communicate. However, his wheelchair was in need of repair, he was not participating in any programs, and he sat home day after day. There was no method available to the young man so that he could communicate his desires. The Advocate in Florida contacted his social worker and was able to effect repairs on his wheelchair. A manual communication system was provided for him and, according to the group home operator, he tells her everything now. Finally, but certainly not least, the young man has been referred for a vocational evaluation.

In another home, an eleven year-old boy with Autism and behavioral difficulties was discovered. The home operators had placed the boy in a metal crib with plywood reinforcement to the ceiling in order to keep him from crawling out. The child's social

worker was aware of the situation, yet did nothing to help. After the Advocate intervened, a behavior specialist was provided to assist the group home operator develop appropriate and safe ways to deal with the young boy's behavior, instead of simply keeping in a crib.

Another example where simple suggestions and intervention on the part of Advocates is beneficial comes from Indiana. A resident in a small group home sustained injuries when his wheelchair rolled down the facility's driveway, across a public street, and dumped him on the ground. Advocates recommended safer procedures for loading and unloading of wheelchair-users in the facility's driveway.

As we see, often simple solutions offer the client's more freedom, mobility, dignity, and safety.

A case in West Virginia offers us a good example of how advocacy not only helps on an individual basis, but in systemic change as well. The Advocate in West Virginia was informed of a consumer who was being discharged from an 8-person home without a discharge plan, or a place for him to go. In essence, this individual ended up being "dumped" on his family, who were unprepared for his arrival. In an effort to prevent "dumping" in the future, West Virginia Advocates worked with the State Department of Health and Human Resources to implement a change in the policy of moving residents from community living situations. The new state-wide policy covers all agencies contracting with the Department and spells out the steps that must be taken to ensure that individuals are

involved, informed, and supported in moves.

California relates a particularly disturbing case of abuse. The Advocate investigated a report of a 24-year-old woman with developmental disabilities living in a licensed community residential facility having been sexually abused. Despite the fact that the resident suffered bruising on her inner and outer thighs, both breasts, and showed signs of possible traumatic sexual abuse, the police were not notified by staff, nor did the facility follow proper sexual assault protocol, provide proper medical attention, or ensure preservation of evidence. Since the Advocate's investigation, the facility has implemented appropriate sexual assault protocol, including training for all newly hired and existing staff.

Massachusetts advocates intervened in a situation where a resident had been verbally and physically abused by a staff member. After several meetings with the client, the woman told the Advocates that she liked her home and wanted to stay, however she wanted the staff person discharged. As a result of the intervention and advocacy, the provider and state agency eventually agreed that there was sufficient evidence of abuse to warrant discharge. Moreover, the residents of the home were to be included in the interviews and decisions about new staff for the program.

Advocates have also been instrumental in enabling residents to exercise rights that you and I take for granted. For instance, in Mississippi, through monitoring and intervention, the P&A has been arranging for residents to have private phone conversations, meet privately

with their girlfriends or boyfriends, vote, prevent staff from going through their personal belongings while residents are at work, allow residents to spend their own money on what they wish, and pursue their education.

Our challenge as the Protection and Advocacy systems is to monitor these programs; investigate complaints or suspicions of abuse, neglect, or poor practice; and pursue administrative or legal remedies until the problems are resolved. Our responsibility has been complicated by limited access to individuals in these programs; inadequate resources to fully implement this mandate; and retaliation by State officials for legal action against them.

As many of you know, the law which authorizes the Developmental Disability Protection and Advocacy program is up for reauthorization this year. In order to increase the effectiveness of the protections and services provided by the Protection and Advocacy system, NAPAS is working to amend the Developmental Disabilities Assistance and Bill of Rights Act. Our first effort is to improve access to clients within institutions and community living arrangements. As it now stands, any client who requests our services has a right to them. A client, parent, or facility staff can contact the local P&A, and if there is just cause, our system can go in and provide services to a client. However, there are many consumers within institutions who are unable to communicate and who have no one to speak for them. These are often the individuals who require our services most desperately. Other clients are unwilling to speak up against abuse or neglect for fear of retaliation. Under our proposed

amendments, our agencies will have the authority to investigate an institution or home in the name of the P&A. This will enable them to reach those who are unable to reach out directly and protect the consumers who are fearful of retaliation.

P&As face another hurdle on a daily basis -- the limits on our resources. Several P&As operate on just over \$200,000, attempting to reach an increasingly vocal and active population. In 1991, over 57,000 cases were opened by the DD P&A programs. Over 14,000 of the cases were assisting people with mental retardation, nearly 4000 of those involving people in group homes and board and care. Over 100,000 people were given information and referrals. As you can see, demand for our services is quite high, however due to our limited resources, P&As are forced into setting priorities in the types of cases that are taken. Unfortunately, too many people are turned away from our doors, due to the lack of adequate resources. In this year's reauthorization NAPAS is attempting to raise the authorization level for DD P&As to \$30 million from its current funding level of \$22.5 million.

Ironically, our programs run the risk of being too effective. If a State views that the P&A agency is becoming bothersome or costly in its pursuits, there may be, and have been, attempts to retaliate by redesignating the program, pulling funding, or freezing staff hirings. The programs are mandated by Congress to be independent of any service provider; however, the Governor must sign the assurances and has the right to redesignation for good cause. In order to alleviate the threat of retaliation, NAPAS is attempting to amend the

DD Act to give P&A systems the obligation to assure their independence. Also, we are attempting to put language in the Act which will prohibit states from implementing hiring freezes and travel restrictions in the use of Federal monies. It is our view that this will make programs stronger and more secure in their efforts to protect the rights of individuals in state-run facilities.

Mr. Chairman, we are committed to giving people with Mental Retardation and Developmental Disabilities the freedom and flexibility offered in a community based system. However, there is no magic inherent in that location. Advocacy must be an important part in realizing the potential of community living.

Once again, I would like to thank you, Chairman Wyden, and the members of this Committee, for allowing me to testify before you today. I hope that I have helped to shed some light on the issues before this committee, but more importantly, I hope I have offered solutions to some of the problems in the form of the Protection and Advocacy System. Please look to NAPAS as a resource to this Committee as it examines these concerns, and as an integral part of reaching resolution.

I would be happy to answer any questions you might have.

Advocacy Center

FOR PERSONS WITH DISABILITIES, INC. - FORMERLY GOVERNORS COMMISSION ON ADVOCACY

March 26, 1993

Mr. Stuart Campbell
National Association of Protection and Advocacy Systems
900 - 2nd Street, N. E.
Suite 211
Washington, D. C. 20002

Dear Mr. Campbell:

This letter is to follow up our conversation yesterday. As we discussed, this is the Advocacy Center's first year of being involved in this type of residential monitoring. We have a full-time staff of two, part-time secretarial support and a growing cadre of volunteers. In our first year, we designed a monitoring system (constantly being updated), and reviewed thirty-one facilities (four facilities were Developmental Services Institutions).

In Florida, there are four Developmental Services institutions and over seven hundred community facilities for people with developmental disabilities throughout the state. The institutions range in size from three hundred sixty-five individuals to almost seven hundred individuals. Community facilities range in size from one person foster homes to one hundred twenty bed ICF/DD. These numbers do not reflect facilities which are designated to serve persons with mental illnesses or Adult Congregate Living Facilities (ACLF), which house persons with developmental disabilities and mental illness.

We have seen some community facilities which were providing a warm and caring environment (a home), and we have seen some facilities which had serious problems. Invariably, the state agency responsible for licensing and oversight has been aware of the problems. In some instances, the state agency had repeatedly documented the problems over several years.

Through our monitoring, we are discovering people in institutions and in community facilities who need protection and advocacy assistance, but do not have the means to contact us. If they have guardians, the guardians have been unaware of the problems, or did not know how to resolve the problems. Some examples of the impact of our program include:

2671 EREC CENTER
CIRC W • SUITE 100
TALLAHASSEE FL 32301-5024
904/488-9077
TOLL-FREE NUMBERS
800-342-0823 (VOICE)
800-346-4127 TDD ONLY

3107 MAGUIRE BLVD.
SUITE 150
ORLANDO, FL 32803
(407) 897-2750
(407) 897-2765 TDD
(407) 897-2763 FAX

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March 26, 1993

One of the earlier community facilities we monitored was a group home for six individuals. The group home operator was providing a warm and caring environment. However, in this home resided a twenty-two year old male who was non-ambulatory and non-verbal. He was quite pleasant, alert and obviously desired to communicate with us. His wheelchair needed repairs. He was not participating in any type of program. Instead, he sat home day after day. We contacted the gentleman's social worker concerning the need for wheelchair repairs, an augmentative communication evaluation and a vocational evaluation. His wheelchair is now repaired. He has a manual communication system. According to the group home operator, he tells her everything now. Finally, but not least, he has been referred for a vocational evaluation.

In another group home, the monitoring team discovered an eleven year old boy with Autism and behavioral difficulties. A metal crib with plywood reinforcement to the ceiling (to keep him from climbing out) was being utilized to curtail his behavior. The social worker for the boy was aware of the situation. Once we intervened, a behavior specialist was provided to assist the group home operator develop appropriate and safe ways to deal with the young boy's behavior.

We intervened to stop the expansion of a program which historically had problems in providing adequate care. Yet, the state continued to relicense the facility and to place more individuals there. We are now in the process of monitoring the changes the facility is reportedly making.

We are currently intervening on behalf of four school-age children in a community facility (out of state placements) who were not being served by the local public school system. Initially, it seems the dispute is over who is responsible.

The unmet health, safety and habilitative needs we found in one of our state institutions were very distressing. We have been very involved in raising public awareness and forcing the state to deal with the problems there. At this time, the top administration of the institution has been removed, and plans have been initiated to reorganize the staff

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to provide more people to work directly with the individuals living there. New staff with expertise in behavioral programming have been hired. There is still much work to be done at this institution, including the development of a comprehensive closure plan.

We recognize that closing large state institutions is not enough. Recognizing the true potential of individuals with developmental disabilities and assuring their protection from harm cannot be achieved by superficial changes in environment. Rather, the deficiencies in programming, training, personnel and oversight will require a substantial commitment over a longer period of time to correct.

I hope this information is helpful to you. If I can be of any further assistance, please do not hesitate to recontact me. Good luck with the presentation to the subcommittee.

Sincerely,

Kathy W. Burton (cpf)
Kathy W. Burton
Regional Unit Director

KWB:cpf

cc: Marcia Beach, Executive Director

CENTER FOR PUBLIC REPRESENTATION

22 Green Street
Northampton, MA 01060

Mental Health Protection & Advocacy Project
Disability Law Clinic

413/584-1844 x 265
586-6024 (TTY)
586-5711 (FAX)

To: Curt Decker
Elizabeth Jones

From: Bob Fleischer

Re: MR Group Home Advocacy

Date: March 22, 1993

M E M O R A N D U M

Although the following case was not a P&A case as such, it may be a useful example of the value of advocacy for individuals with mental retardation who live in less than adequate community facilities.

CPR received a call from a therapist who, with her client's permission, told us that the client, a young woman with mental retardation, said that she had been verbally and physically abused -- slapped -- by a live-in staff member of her residential program. The staff person vigorously denied it, but the therapist believed that her client was telling the truth. Other than the staff person and the client, there were no witnesses to the incident.

An investigation by the state agency responsible for the program had been inconclusive, but had found other irregularities in the staff person's conduct, including the falsification of some records and the failure to adhere to aspects of the client's written treatment plan. The residential provider agency had disciplined the staff person, but he remained working in the residence.

A CPR attorney met with the young woman to gather the facts and to ask what she wanted to happen. After several such meetings, some including friends and housemates, and after considerable thought, the woman told CPR that she had decided that she liked her home and wanted to stay there, but that she wanted the staff person fired.

As a result of CPR's intervention and advocacy, the provider and the state agency eventually agreed that there was sufficient evidence of abuse to warrant discharge. The provider also agreed to include the young woman and her housemates in the interviews and decisions about new staff for the program.

* * *

Cathy Costanzo may also have a good case example for you when she return from New Mexico in the next day or so.

I hope this is helpful. Enjoyed seeing you both at the excellent management conference in Dallas (?) last week.

Kansas Advocacy & Protective Services, Inc.



2601 Anderson Ave., Manhattan, KS 66502-2876

(913) 776-1541, FAX (913) 776-5783

Kansas City Area
6700 Squibb Rd.
Suite 104
Mission, KS 66202
(913) 236-5207

Wichita Area
255 N. Hydraulic
Wichita, KS 67214
(316) 269-2525

MEMORANDUM

March 26, 1993

TO: Stuart Campbell, NAPAS, 900 Second St., NE, Suite 211,
Washington, DC 20002

FROM: Kansas Advocacy and Protective Services, Inc., 2601 Anderson Ave,
Suite 200, Manhattan, Kansas 66502-2876

RE: Urgent-Immediate Request for Testimony on small and community
based housing for People with MR/DD

We have reviewed and analyzed 84 reports of community-related incidences received by our agency, 2 from 1989, 21 from 1990, 22 from 1991, and 39 from 1992 (through October, 1992). Although these reports do not constitute all contacts with our office during the period in question and are not necessarily fully representative of community problems or proportional to their actual incidence, they do give a general idea of common problems that are now being faced.

The subjects reported include allegations of abuse of persons with disabilities, terminations from facilities or programs, personal or financial exploitation, neglect, sexual abuse/sexual exploitation/consent issues, inappropriate transfers, ineffective programming or (other) civil rights violation; concerns were also received involving criminal law issues.

Following are a few examples selected as representative of some of the given areas.

A man with mild mental retardation and some physical disability had problems in the past with minor theft incidences, but was doing rather well in a relatively structured, congregate living setting. The IPP team determined that due to the past problems he should stay in his present setting rather than move into a lesser restricted living environment; however, he was in fact staffed into a more independent living setting, but after more minor theft incidences occurred, he was terminated from the program, with little or no post-discharge planning, and became homeless.

KAPS has been charged with developing systems of advocacy and protective services in Kansas relevant to the provisions of Sec. 113 of P.L. 94-103, as amended; the Developmental Disabilities Services and Facilities Construction Act, and P.L. 99-319, the Protection and Advocacy for Mentally Ill Individuals Act.

KAPS was contacted, and with assistance from KAPS, the man was placed into an independent living setting and independent living services were provided through employees of the CMRC, who proved to be excellent. Problems with the social security checks were ameliorated also.

A young woman attended a CMRC workshop and lived at home, where it was suspected that the family was exploiting the woman by improperly using her SSI check, and occasional physical abuse was also suspected.

After a consumer training (and with continued consultations) by KAPS, the consumer became more aware of her rights and chose to no longer live at home with her family, moving instead to a small group home; but still retaining contact with her family.

We were contacted by a family member of a person who had been apparently subjected to repeated sexual and physical abuse in a CMRC by a roommate. The possibility of the abuse may have been known by direct line staff for some time. The report that we received was that this matter was not reported due to intervention from persons higher in the hierarchy of the community based agency. In this situation the family had retained legal counsel, but did not wish to sue the facility and did not do so because of the fact that the facility took subsequent steps to ameliorate the situation.

In this situation, KAPS had provided consultation to the family, emphasized the importance of documentation of incidents, and provided information on client/consumer rights. KAPS' involvement in situations involving sexual abuse and consent issues among persons with disabilities has since extended to doing informational in-services, borrowing heavily on information disseminated by the New York P & A.

A situation came to KAPS' attention regarding general programmatic issues of concern in a CMRC group home and workshop, and specific concerns of apparent physical injury.

KAPS, in cooperation with the local adult protective services office, investigated the specific issue of concern, and additionally provided follow up consultation with family and facility on general group home and sheltered workshop programmatic concerns. KAPS commonly conducts in-services on consumer rights issues to CMRC staff and/or consumers, as requested.

Please advise if we can be of further assistance.

IOWA PROTECTION AND ADVOCACY SERVICES, INC.

"To defend and promote the rights of individuals with
developmental disabilities and people with mental illnesses"

Mervin L. Roth
Executive Director

MEMO

TO: Stuart Campbell
NAPAS

From: Mervin L. Roth, Executive Director *Merv*

Date: March 26, 1993

Re: Testimony Request

In response to your request for potential testimony for next week, the example below is the best I could do on short notice and with four staff out of the office today. Good luck and feel free to call me if you have any questions.

Over the past 2-3 years several MR/DD residents of small community based residential facilities in Iowa became clients of Iowa P&A after they received involuntary discharge notices from their facilities due to problematic or difficult behaviors. P&A represented these clients and forced the facilities to obtain and utilize additional behavior management information and resources for implementation in the residents individual program plans and thereby prevent the discharge from the facility.

MLR/bf

Central Office
3015 Merle Hay Road • Suite 6 • Des Moines, Iowa 50310
Telephone Number 515-278-2502 • Clients Call Collect
Fax 515-278-0539 • TDD 515-278-0571

Developmental Disability and
Mental Illness Clinical Law Project
University of Iowa College of Law
Iowa City, Iowa 52242
319-335-9021

"Advocacy Services Saves Group Home: Triggers Investigation into Improper Use of Client Funds"

Without notice to guardians or residents, the Kodiak Island Mental Health Center attempted to close a group home providing services for six persons with developmental disabilities. Advocacy Services of Alaska (ASK) learned of the unilateral decision to close the facility when a guardian of one of the residents was informed by a bank teller at the local bank. The move was intended to take place on Saturday, in two days.

On Friday, ASK filed a Motion for a Temporary Restraining Order and a Complaint with the Federal District Court in Anchorage. The Motion and Complaint were faxed to the Island of Kodiak to stop the move. The move was stopped. The Center entered into a settlement agreement with ASK for due process protections: prior notification and opportunity to be heard to be provided to guardians and clients in a timely manner.

The action in Federal Court, as well as the publicity, prompted an investigation into the practices of the Kodiak Island Mental Health Center's programs. As a result, responsibility for the program was awarded to another provider.

MICHIGAN PROTECTION AND ADVOCACY SERVICE

March 26, 1993

To: Stuart Campbell/NAPAS

From: Mary Beutler/MPAS

Re: Testimony on small and community based housing for People
with MR/DD

I was recently involved in monitoring a case in which our client was a young woman with a complex history of both emotional and cognitive impairments. At the time of our client's release from a state psychiatric hospital, the community mental health agency (CMH) in her county of residence decided that they could not meet her habilitation and treatment needs because of her challenging behaviors. They made a contractual arrangement with an out of county adult foster care (AFC) provider who agreed to provide residential, programming and casemanagement services. The contracting CMH was to provide a minimum of monthly review of records and visitation with the client by a member of their treatment team to ensure that the client was benefitting from the placement and services.

This agency became involved when our client's mother called us, claiming that her daughter was sick and dying as a result of being administered prescription drugs that interfered with a possibly life-threatening health condition which her daughter had developed. She also claimed that necessary medical intervention for her daughter had not been sought by the AFC provider and that her daughter told her that she (our client) and other female residents of the AFC program frequently experienced physical and sexual abuse by male program staff and male program residents.

Upon investigation, we found that our client was experiencing a health emergency and was not getting adequate intervention. Interviews with our client and other program residents and staff strongly suggested the probability of abuse of female program residents. Physical conditions of the AFC homes included bare electrical wires, bedroom doorways with sheets hung for doors and generally shabby conditions. Medication and programming records for our client were not available in the home. Review of the client's records held by CMH indicated that they were not providing the regular monthly visits to the client and review of records to be kept by the AFC provider. The AFC provider was receiving approximately \$2000 per month to provide care and services for our client.

Following our investigation, our client returned to her parental home to stay and the local (county of residence) CMH was developing a locally based plan of service for her. Various complaints had been filed against the AFC provider regarding conditions in his residential programs.

WV VA

West Virginia Advocates

MEMO

To: Stewart Campbell
 From: Fran Allen *Fran*
 Date: March 26, 1993
 Re: Feasibility and Efficacy of Monitoring Community Placements

West Virginia has a regionalized advocacy program for people with developmental disabilities that allows for high visibility among consumers, providers, and other people in the community.

We received a call from the family of an individual who was being discharged from an 8 bed ICF/MR without a discharge plan, and no place to go.

We discovered that the State's licensing division had de-certified the bed that individual represented, saying that his placement there was inappropriate. The ICF/MR provider had unsuccessfully attempted to involve the Behavioral Health Center in discharge planning, and had finally determined to discharge the person anyway.

As the Center had nothing else ready, he went to live with his family, despite their being totally unprepared for him. His behavior became aggressive and the Center had him committed to a state psychiatric facility.

We intervened both individually for him (he now has a trailer, 24 hour support staff, and supported employment), and on a systems level to prevent future "dumping".

We instigated a West Virginia Department of Health and Human Resources policy change process by contacting Petitioner's Counsel and the Court Monitor in our state's ongoing behavioral health system litigation, and asking their assistance.

Over the course of several months we participated in an interagency process of development of what is now the "Change in Community Residence of Persons with Developmental Disabilities" policy. This is a Departmental policy that covers all agencies that contract with the Department, and spells out the steps that must be taken to insure that individuals are involved, informed, and supported in moves.

The policy includes such things as:

1. procedures for notification of a request for change (and who is entitled to request such)
2. the information sharing that must occur (and the forum in which this is to take place),

Campbell
Page 2

3. what steps must be taken as a decision is made (e.g. addressing advantages and disadvantages of a move--specifically mentioned are such things as maintaining/developing family and social ties, potential for long-term opportunities for personal growth and long-term stability of residential service)
4. planning for alternatives should the new placement not meet the person's needs
5. planning for increased monitoring during and immediately after the move
6. assurance that the individual has the opportunity to visit the place he/she (or the guardian) is choosing to move before any movement occurs
7. assurance that no move takes place within 30 days of the planning meeting, unless the individual chooses to do so, or there is mutual agreement
8. planning for information sharing/training on specific programs
9. assurance that there will be a written discharge plan
 - statement of who must participate
 - what issues must be addressed
 - who the plan is shared with
10. clear delineation of the responsibilities of discharging and receiving providers
11. what is to occur if case management responsibility is also changing
12. what differs in procedure for emergency or temporary moves
13. assurance that the individual's preference is to be adhered to
14. assurance of appropriate follow-up services
15. directions for Appeals of decisions to move
16. steps to be taken if there's a need for psychiatric stabilization of a diagnosed acute mental illness (and these very clearly spell out alternatives short of commitment that must be taken)

Hope this is helpful, Stewart.



Mississippi Protection & Advocacy System, Inc.

4793B McWillie Drive • Jackson, Mississippi 39206 (601) 981-8207 • 1 (800) 772-4057 • TTY

MEMORANDUM

TO: Stuart Campbell, NAPAS

FROM: Polly Tribble *pt*

DATE: March 26, 1993

RE: Testimony on small and community based housing for People with MR/DD

The complaints that I have received are violations of persons' with developmental disabilities rights. I was not sure if you could use these examples, but I am sending them anyway.

1. People living in group homes have asked for privacy while using the telephone. We have suggested installing remote phones (receivers can be taken to their room) to promote privacy. People living in group homes have also requested the opportunity to have privacy with their girlfriend/boyfriend. We helped establish rules that allow for such requests.
2. Some group home residents have requested the opportunity to vote. The staff were putting these people through "voting school" before they could register to vote. In Mississippi, there is no need for that. We enabled who wanted to register vote the opportunity to do so.
3. In the community group homes, people were complaining that while they were at work during the day, staff were searching through their drawers and putting away their things. After meeting with administration, staff do not invade these people's privacy now.
4. People living in group homes also claimed that group home staff were not allowing them to spend their money as they wished. Staff made one client buy a television with his personnel funds so they had a television for everyone in the den. Staff also would not give group home clients as much money as they wanted to go on trips, to go to the movie, or to go shopping. The staff said that the people living in group homes "did not need that much money". With our instruction of these staff, they realized that they cannot control decisions made by people.

5. Some people living in group homes requested the opportunity to work toward their GED. Other people living in group homes showed an interest in taking classes at a local community college. Some staff said that "they might not do well in school". Staff also stated that "the other kids might make fun of them". With MS P&A education training, we showed staff that these people living in these community homes certainly have the right to take risks. Everyone should have the opportunity to further their education. And, we all have the right to take risks!

I certainly do hope that this helps. Good luck!

UNITED STATES DISTRICT COURT
DISTRICT OF NORTH DAKOTA
SOUTHWESTERN DIVISION

Case Order

Association for Retarded Citizens)
of North Dakota; Lindley Black, by)
his father, Sidney Black; Bradley)
Cossette, by his mother, Denise)
Cossette; Richard Schneiderhan, by)
his mother and guardian Elmira)
Schneiderhan; Naomi Jordison, by)
her father, Timothy Jordison,)
Kelli Moriarty, by her mother and)
guardian, Jacquelyn Moriarty; and)
Philip Dechant, by his mother and)
guardian, Lois Dechant: on behalf)
of themselves and all others)
similarly situated,)

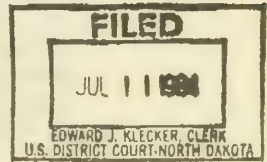
Plaintiffs,)

vs)

Civil No. Al-80-141

Allen I. Olson, Governor of the)
State of North Dakota; Alton L.)
Lick, Director of Institutions;)
Milton Wisland, Superintendent of)
Grafton State School; Richard)
Charrier, Assistant Superintendent)
of Grafton State School and Chief)
Administrative Office of San Haven)
Division; Dr. M.A.K. Lommen, State)
Health Officer, Department of)
Health; Sam Ismir, Director,)
Division of Mental Health, Depart-)
ment of Human Services; Darvin)
Hirsh, Director, Division of)
Developmental Disabilities, Depart-)
ment of Human Services; Carroll)
Burchinal, Director of Department)
of Vocational Education; Dr. Joseph)
Crawford, Superintendent of Public)
Instruction; Gary Gronberg,)
Director of Special Education)
Division of Department of Public)
Instruction; Dale Moug, Acting)
Director Department of Human)
Services; James O. Fine, Director)
of Division of Vocational Rehabil-)
itation, Department of Human)
Services; Marcellus Hartze,)
Director of Division of Community)
Services, Department of Human)
Services,)

Defendants.)



1. The advocacy program shall be vested in the existing Protection and Advocacy Project under the supervision of the Executive Committee of the Governor's Council on Human Resources. . . .

2. The independence of the Protection and Advocacy Project shall be guaranteed by the defendants except that its expenditures shall be in accordance with state law. Fiscal control by the defendants shall not have the effect of reducing the scope or affect of this order.

3. The Protection and Advocacy shall consist of:

1. Executive Director
2. Deputy Director for Volunteer Services
3. Secretary
4. Eight Regional Advocates
5. Two Institutional Advocates
6. One Secretary for Institutional Advocates
7. Clerical support office space and office equipment shall be provided by the Regional Human Service Centers and the Institutions at Grafton and San Haven at no cost to the Protection and Advocacy Project.
8. Readily accessible legal support

4. Sufficient funds shall be allocated to the Protection and Advocacy Project to hire and maintain qualified personnel and to provide for adequate travel, supplies and training. }

5. The defendants shall post in every licensed program, Regional Human Service Center, and in the institution at Grafton and San Haven a prominently displayed notice that every resident and client are entitled to representation by an advocate.

6. The defendants shall include in the requirements of this court's order of March 6, 1984, Paragraph 100 that clients and residents are entitled to the representation of an advocate and information

must be disseminated to the general public identifying the means by which advocates may be contacted.

7. Advocates shall be assigned no duties or obligations which conflict with their responsibility to represent a client or resident. Advocates shall not be visitors in guardianship proceedings.

8. If a client or resident is represented by an advocate, the advocate shall be informed of and invited to all Individual Habilitation Plan meetings, staff meetings or any other forum established which may make decisions significantly affecting the resident or client. A resident or client may give their informed consent stating their wish that the advocate not be present. The written record of any such proceeding must document that the client or resident did not wish the advocate to be present.

9. The Case Management System staff and social work staff at Grafton and San Haven shall include as an integral part of their functions providing release of information forms to clients, residents, parents, and guardians to facilitate advocacy representation. Pamphlets, brochures, or other informational materials describing advocacy services and how they may be obtained must be distributed to all clients or residents, parents, guardians or concerned family members.

10. Advocacy services provided for residents and clients shall be based upon their needs as individuals. Advocates shall not duplicate or supplant functions performed by licensed providers, case management system, or the institutions at Grafton and San Haven. Advocates are to represent residents and clients, where required, to assure that their rights are observed by these entities.

11. Accordingly the Protection and Advocacy Project shall provide:

1. Case Advocacy
2. Protective Services
3. Residential Advocacy
4. Systems Advocacy
5. Citizen/Volunteer Services
6. Self Advocacy

The description and objectives of the above are appended hereto and are a part of this order.

12. The Monitor shall at intervals of six, twelve, and twenty-four months from the date of this order report to this Court regarding the status of the Protection and Program Advocacy Project with respect to:

1. the adequacy of financing
2. the adequacy of staffing
3. the quality of representation afforded clients and residents
4. the obstacles to project effectiveness
5. the incidence of project use by clients and residents and
6. Project achievements

13. The Monitor may, pursuant to Paragraph 140 of the Court's Order of March 6, 1984, make suggestions to the Protection and Advocacy Project to facilitate compliance with this and other Orders of the Court.
14. The Monitor shall, upon a finding of inadequacy or deficiency in the project, invoke Paragraph 145 of this Court's Order of March 6, 1984.
15. The Monitor may establish reporting requirements for the Protection and Advocacy Project, hire consultants to evaluate the project, or use other reasonable means to secure information regarding the project.
16. The Protection and Advocacy Project shall provide access to all aspects of the project and report to the Monitor any obstacle to compliance with this Order.
17. The Protection and Advocacy Project shall immediately seek AC/MRDD accreditation and secure accredited status by July 1, 1987.

WRITTEN TESTIMONY

on

**The Growth, Successes and Short-Comings of Community Based Housing
Programs for People with Mental Retardation and Developmental Disabilities**

Respectfully Submitted

to the

**United States House of Representatives Committee on Small Business
Subcommittee on Regulations, Business Opportunities, and Technology**

The Honorable Ron Wyden, Chairman

Presented by

Jay Klein

**Director of Training and Dissemination and Coordinator of New Hampshire's
Home of Your Own Project, Institute on Disability, University of New Hampshire**

March 29, 1993

Thank you for this honor to be given an opportunity to testify before you on the issue of the growth, successes and short comings of community based housing programs for people with mental retardation and other developmental disabilities. I'm proud to be a citizen in a country where ordinary people are given a chance to express our opinions to our elected officials about issues effecting our country. My personal and professional experiences over the last twenty years have centered around issues which effect the everyday lives of people who have mental retardation and other developmental disabilities.

Over the past ten years I have been intimately involved in learning about the housing and support needs of people who have disabilities. In this effort I have had the pleasure of traveling throughout the country meeting with people with disabilities, parents of people with disabilities, residential agency personnel at all levels, and local, state and federal government officials. It is with these experiences that I come before you today to outline where we have been, where some people have been led, and where I think we need to go. Before specifically addressing your questions I will outline some of the issues I will be discussing.

Throughout my testimony I will be asking you to imagine what you would want your life to be like if you had a developmental disability. Does the American Dream hold true for all of us? I believe that we will continue to respond in many of the ineffective and costly ways that we have in the past until we can truly imagine what we would want for ourselves if we were persons with disabilities.

Our major problem centers around an existing myth that somehow we can create a perfect program or service which will meet all the needs of the people who receive its support. If we believe in this myth of perfection we believe that somehow we can create the perfect situation where people will be free of pain, disappointment, depression, mistakes, diversity and problems. In addition, some believe that through mandates, policies, procedures, regulators, professional control and standardization this perfection will exist. In their book "Imperfect Change", Beth Mount, George Ducharme and Pat Beeman address this promise of perfection in the following way, "Many people with complex disabilities depend on human service systems for needed support. Users of services are often seen as objects to be processed by efficient service units. As objects people's interests are often ignored, sometimes exploited by the services which impose ill-fitting supports onto people who already suffer. People may often be more hassled than they are helped in these services.

These services rely on standardized designs for service delivery that do not account for the interests of people or the resources in local communities. They emphasize legal charters, formal authority, and control structures to motivate action. They depend on 'value free' methods of decision analysis which exclude the richness of people's experience. They are usually large bureaucratic structures which do not reflect the interests of people."

It is time for us to reject this myth and realize that life is imperfect and that all people experience peaks and valleys as they grow. Maybe the role of human service needs to be to figure out how to provide people with the support they need through those highs and lows. The authors of "Imperfect Change" state, "Personal Stories of change seem filled with imperfection. Things don't go as we planned. If we are lucky, we have as many positive surprises as we have disappointments; we make progress in spite of our limitations. If we are not so lucky, the disappointments outnumber the gains. We sit month after month, year after year, in the same place. We search for things to celebrate, for reasons to laugh. We take time to celebrate the smallest breakthrough, the rays of hope. And things do change when we sustain our commitment, and don't jump ship because we can't face our sense of helplessness."

We must begin to learn from the experiences of many people who have been living with disabilities at a personal level. For example, many parents rejected the advice of friends, family and professionals to institutionalize their children with disabilities. Some of these families tried to have as typical a life as possible, including their family member with a disability in all the activities that they would participate in. Somehow these families met the health, safety and social needs of the member with a disability without any formal training. In some families when the person with a disability becomes an adult and the family cannot meet his or her assistance needs, the person enters the human service system. Suddenly the person requires certified professionals, goals and objectives and active treatment to meet those same needs.

In response to a number of court cases that mandated the deinstitutionalization of people with disabilities from large congregate care facilities to smaller, community-based residences (cf. *Halderman and the United States v. Pennhurst State School and Hospital; Wyatt v. Stickney*), there has been extensive development of residential services around the nation. Although this movement was based on an ideology aimed at enhancing the quality of life for people with disabilities, those people with the most intensive support needs who left the institution still meet with few options for where they can live. Typically, the options are living situations in which people are grouped with other people who have severe disabilities. Furthermore, these community-based options frequently exclude people from the neighborhoods and communities to which they have moved by creating separate buildings, programs, services, and activities.

The time has come to focus our attention on alternative approaches to these community-based services so that people with disabilities are embraced by their communities as valued members. Through a compilation of personal stories that illustrate a novel approach to community supports by a program in Greeley, Colorado, that evolved and changed along with the people it was attempting to assist, I will answer your questions by presenting a set of values and a way of thinking about the provision of support to persons with disabilities. A portion of this written testimony will be taken from a recent chapter I authored titled "Get Me the

Hell Out of Here: Supporting People with Disabilities To Live in Their Own Homes." The book titled, "Natural Supports in School, at Work , and in the Community for People with Severe Disabilities" was published in August of 1992 by Paul Brookes and edited by Jan Nisbet. I will end this written testimony with some specific recommendations on ways we can continue to move forward.

JEANNE'S STORY

"Her major problem seems to be that she has difficulty accepting her limitations" (Kelsey, 1984).

We first met Karren, Sharon, and Jeanne on one of those visits that private residential providers often make to state institutions for people with disabilities. Our agency had been given money to assist three people from an institution of 357 to move 300 miles away to our community. Upon our arrival, we were given a stack of papers on people who were identified as being ready to leave. We sat down and began reading, but after 2 hours we decided something was wrong. Knowing that we had a limited amount of time, we negotiated a different way to spend our time. We decided to use the rest of that day into the evening and the next morning to meet about 60 people to talk about what it would be like to leave this institution to come to our community.

We met Jeanne at about 9:00 P.M. after interviewing about 30 people. Jeanne was among a group of about eight people all preparing to go to bed. Our introduction began with discussing our plans to provide support to people based on their needs and desires rather than fitting them into some sort of program. Jeanne, who does not speak many words or use her legs or arms very much, was using a head pointer and a lap word chart to communicate. She motioned for us to come closer. When we were in front of her lap chart she spelled, "Get me the hell out of here."

We spent the next one and half hours finding out what Jeanne wanted in a home at this point in her life. She was clear that she wanted to live in a place where she could be close to other people who had physical disabilities so she could learn ways they dealt with barriers with which they were confronted. The next day, Jeanne tracked us down while we were visiting some other people to ask us a few more questions. She explained that a few weeks before, she had been rejected by another program that specifically worked with people who have physical disabilities because they said "her disabilities were too severe." She was concerned that we might also turn her down. We told her the decision was now going to be hers and that we would arrange for her to visit to our community within next month.

In reviewing Jeanne's records, we found that she had been institutionalized since age 4 and was now 26 years old. Professionals attached labels to her of mental retardation, psychomotor seizures, severe cerebral palsy with spastic quadriplegia, mental deficiency due to encephalopathy due to anoxemia at birth, and nonverbal. They stated that her rehabilitation potential was poor. Her psychology report

concluded, "Her major problem seems to be that she has difficulty accepting her limitations and these can be frustrating at times. When this happens she sometimes gets into a negative emotional state in which she may feel sorry for herself or blame others" (Kelsey, 1984). Despite this negative personal description, the records also seemed to suggest that Jeanne received preferential treatment by some of the people who worked in the institution because of her likable nature.

When Jeanne arrived in Greeley, Colorado, for a visit in September of 1985, we came to know each other better. We had arranged for Jeanne to stay at an apartment in a complex of 16 apartments designed for people with physical disabilities. This complex had 24-hour nursing and attendant care.

Jeanne had decided that she wanted to live at this place. Upon our inquiries, we discovered that an apartment was not available for 2-6 months. At this point, we presented Jeanne with the option of going back to the institution and waiting until the apartment was available, or looking with us for another apartment in our community immediately. She then explained emphatically that she would go back to the institution only to collect her things and to say goodbye. She wanted this apartment and she trusted that we could make this move a reality. After some negotiation, we arranged for Jeanne to stay with Carolyn (a person who already had an apartment) for a few months. On October 1, 1985, Jeanne arrived to sleep on Carolyn's couch.

The next 5 years came and went so quickly, and we all grew tremendously. Jeanne finally got her own apartment, which she shared with another woman for a few months. When there was an opening in another apartment, she decided to take it, stating, "I have lived with people all my life and it is now time to live by myself."

In 1986, a surveyor from a certifying agency came to check on Jeanne's safety. She had been working with her support person and was well prepared. When asked how she would obtain help in case of a fire, she rolled over to the telephone and pressed the emergency button on it with her head pointer. When asked how she would do this if she did not have the pointer on her head, she smiled and had someone remove the pointer. She then proceeded to swing her arm up and hit the emergency button and the disconnect button simultaneously. We do not know if Jeanne has ever done this since, but at the time we celebrated!

Jeanne continued to meet people who became interested in getting to know her. She has made friends throughout her community and learned ways to negotiate public transportation to shop, recreate, and visit people. Jeanne shops in the supermarket with the assistance of a grocery store employee. She continues to increase her vocabulary and now programs a voice communication board. Jeanne has volunteered in a neighborhood preschool and would like to do this for pay someday.

In June of 1986, Jeanne had an acute episode of appendicitis. Luckily, the support system that had been established worked, and she was rushed to the hospital and treated. In December of that year, she also received a Colorado Developmental Disabilities Planning Council travel grant to visit Berkeley, California and, as she says, "explore the wheelchair capital of the world." During this trip Jeanne spoke to about 100 people from all over the world at The International Association for People with Severe Handicaps Conference. That presentation can be summed up by a note received from Channon Aharoni of Israel that stated, "I have traveled 6,000 miles to this conference and if this is all I see, it would have been worthwhile."

Three years after Jeanne moved into her own apartment, she decided to move out. She cited a variety of reasons, ranging from dissatisfaction with the attendant and nursing care she was receiving at this complex to wanting to have a dog. Jeanne arranged to move across town to another complex with accessible apartments. This new apartment complex was not specifically designed for people with physical disabilities. However, there were some apartments within the complex that were made accessible so that people with physical disabilities could live there.

Jeanne continued to be adamant about not having a roommate. The challenge to those people who provided assistance to Jeanne was to determine how to provide the intensive support that Jeanne needed without having somebody live with her at all times. The solution was to create a support system in which an attendant came to Jeanne's home four times a day, for about 2 hours each time, and neighbors agreed to respond in the case of an emergency.

Jeanne and her support team faced a second safety challenge when she became ill and began to choke. The concern was that Jeanne would choke in the middle of the night when no one was available to help. Immediately, discussion began about the need for a roommate. For the period of that sickness, a person was found to sleep on her couch temporarily and Jeanne agreed to find a roommate. When Jeanne recovered from her illness, one of her support people suggested that if she was still against having a roommate, people could be found to sleep on Jeanne's couch the two to three times a year that she might be sick. Jeanne was delighted and chose this solution instead of having a permanent roommate. Although this solution was not considered ideal by many of the people who would have felt better had there been someone with Jeanne at all times, it represented respect from those people who cared the most about her desires, her preferences, and her right to control her own situation. In addition, people respected Jeanne's right to take certain risks. These risks were minimized by the fact that someone would be attending to Jeanne's needs four times a day and that someone would stay with her overnight if she became ill.

Later in that year, Jeanne was given a dog by a friend. This dog has become a faithful companion to her, and they go everywhere together. Jeanne says she would like to have another dog that could be trained to turn lights on and do other things that she finds difficult to do. Jeanne's future plans include moving to another state that has a warmer climate and getting married in July of 1993.

RESPONSE TO YOUR QUESTIONS:

1. **In your opinion, what constitutes both the worst and best practices in programming for people with mental retardation and developmental disabilities?**

The proceeding story of Jeanne demonstrates some of the best practices in "programming," which I will elaborate on in greater detail later in this testimony. In my opinion the worst programming most often exists in large congregate institutional settings, although many of the same practices which make this the worst "programming" often exist in smaller group living housing programs.

Components of Traditional Residential Services which Constitute the Worst Programming

Traditional residential services create places where people with disabilities went and often continue to go to get the services and treatment they need. In this section are presented the components of traditional residential services which address where we have been and in many cases still are: program and professional paradigm, readiness and movement, community-based services, determining ability through assessment, and criteria which determine expectation.

- **Program and professional paradigm.**

Although many of the places where people live are called houses or homes, both people who work and live in these places describe them as programs. They are typically referred to by an agency name (UCP group home), provider name (Warehimes group home), street name (Alder Street group home), famous person's name (Ronald McDonald group home), or a corporation name (New Life Center, Inc.). By giving programs professional sounding names, it follows that these programs then need professionals to work in them. These professional must be well trained certified experts who know how to provide programming and deal with the problems that will arise within the programs.

- **Assessment Driven Readiness and Movement.**

Most residential services have been developed on a theory called continuum of services. According to the continuum theory, a person starts at the place that is considered the most restrictive place or setting possible. The person then moves on as more training or skills are acquired and, in turn, becomes ready for a less restrictive setting. In theory, people progress through the continuum, stopping at each level, which has a less restrictive setting than the previous one, receiving more training and skill development until they become ready to live in the least restrictive setting.

Each level of the continuum is attached to a program, which, in turn, is typically attached to a building. The people with the most intensive support needs have usually ended up in the bigger buildings. The more intensive the support needs, the bigger the building. Consequently, the people with the most intensive support needs received services that were designed to meet the needs of a greater number of people (cf. Taylor, 1987).

People are labeled differently based on where they are located on the continuum. If a person recently entered the continuum, he or she most likely would be considered to have many difficulties. As that individual moved to the next levels, he or she would be viewed as having fewer difficulties. Additionally, each place or building that people live in receives a label based upon where it falls on the continuum. A place where people with more intensive support needs live might be called "the home for the severely involved, the intensive developmental home, or the maximum supervision home." The people living there take on this label and it becomes a self-fulfilling prophecy for those who surround the person. The workers providing support to the place then become the agency experts on that particular label. For example, a home for people who were labeled "borderline" would have staff who are experts on "the borderline."

Most continuums of service have some type of entrance criteria for each level that people must meet. The criteria again sets up situations in which people with the most support needs are placed in the largest buildings with the greatest number of people. Assessments are then developed to determine the intensity of people's support needs. In essence the assessments, which are based on what people cannot do, are then used to place a person at some level in the continuum. Many of these assessments have been standardized with reliability and validity measures. Once people enter this continuum at any level, they have to meet additional predetermined criteria for movement to the next level or place to live. The people with the most intensive support needs (by virtue of these criteria and resulting assessments) are determined to have the most upon which to improve. Consequently, they have the most goals and objectives to work on and are required to change the most in order to move to the next level (cf. Wieck & Strully, 1991).

Additionally, in order to move to the next level, people have to jump through a series of hoops for an ever-changing set of staff persons. People are put in a situation of having to prove themselves in order to be allowed to move on. At each level there are rules and regulations that people are expected to follow. Along with these rules and regulations come consequences for noncompliance. Success or failure is totally dependent on the individual and not on a place or program's inability to meet his or her support needs. Even though the criteria are specific, movement to the next level is usually dependent upon the relationship between the person and the staff people responsible to him or her. In many cases, this sets up a situation in which people either never move to the next level or are moved back a level because they cannot continue to meet the criteria.

Once people are accepted into programs, they are expected to progress through some sort of continuum. The professionals involved then put together a treatment plan and training schedule, resulting in what is called an Individual Habilitation or Service Plan. This plan is said to be designed to help people attain the skills necessary to move to the next setting the continuum, or a less restrictive setting. If things do not go well for people in programs, sometimes they are moved to another (more restrictive) program where professional services are better designed to meet their needs.

- **Community-based services**

Inherent in the name "community based services" is the assumption that such services are based or located within the community. However, despite the common belief that people's presence in a community makes them an actual part of that community, this is hardly the case. Not only are people living in places referred to as "home-like" and "family-like" rather than in homes or with families, traditional community-based services do little toward assisting people to assume roles, responsibilities, and activities that make them a part of their community.

- **Criteria which drive expectation**

Each program has its own set of entrance criteria. In order to be eligible to get into a certain program, people need to have or not have some predetermined characteristics. For example, the entrance criteria might state that the program accepts only people who need 24 hour supervision, know how to cook, can take care of their personal hygiene, have a physical disability, have autism, do not need more than 3 hours of attendant care, or are visually impaired. Once people enter this continuum at any level, they have to meet additional predetermined criteria for movement to the next level or place to live. The people with the most intensive support needs (by virtue of these criteria and resulting assessments) are determined to have the most upon which to improve. Consequently, they have the most goals and objectives to work on and are required to change the most in order to move to the next level (cf. Wieck & Strully, 1991).

2. **Are community based and small group living housing programs for people with mental retardation and developmental disabilities meeting the needs of this population?**

While it is true that the period from the 1960s into the 1990s has seen a decrease in the numbers of people with disabilities who have been institutionalized, many people with the most intensive support needs continue to remain in group living settings. Many residential programs tend to offer people only homes away from their communities, shared with many other people who have intensive support needs, further contributing to their isolation from family, friends, and regular community resources (O'Brien, 1986).

In a brief review of the literature on deinstitutionalization, Walker (1987) stated:

Since the late 1960's, effort has been placed on the deinstitutionalization of people with developmental disabilities from large facilities to smaller community-based residential settings. The institutional population peaked at 194,650 in 1967. Since that time, the number of people in institutions has steadily decreased to 100,421 in 1986. However, a disproportionate number of people with more severe and multiple impairments, as well as those with challenging behaviors, have remained in institutional settings. If they moved, it was often either to other institutions (i.e., nursing homes) or large facilities (i.e., with sixteen or more residents). (p. 1)

In many places the combination of changing public policy and the use of simple technology is facilitating the provision of support to people with disabilities living in their own homes. Some people still believe that people with the most intensive support needs will always need medical and behavioral controls provided in congregate and restrictive settings. Others, however, believe that what these settings provide for people that might not be obtained in their communities is segregation (Green-McGowen, 1985).

Walker (1987) offered the following summary of the most critical issues relative to community support for people with severe disabilities:

In the past few years, there has been a recognition that all people with disabilities, including those with the most severe impairments, have the right to live in the community. "Living in the community," however does not just mean placement in a residential neighborhood. Research has demonstrated that even in smaller settings, such as group homes, the residents can still be very isolated from the surrounding community. Rather, it involves participation in the community—the opportunity to have interactions with and form relationships with other community members. Thus, the issues facing human service providers, as well as society as a whole, have begun to shift from the debate over whether people with severe disabilities can live in the community to how best to support people with severe disabilities in the community; from a focus on deinstitutionalization itself to promoting quality of life and community participation for all. (p. 1)

In most situations small group living housing programs for people with mental retardation and developmental disabilities have improved many of the inhuman conditions people experienced in large institutional settings. Unfortunately, although much has changed for people by virtue of being in a smaller group living situation the vast majority of people with disabilities' needs are not being met in these small group living facilities.

Having seen the apparent inconsistencies and dehumanizing characteristics of operating residential services using the traditional residential service components described above, some programs have made significant changes in an attempt to be more responsive to what they believed people with disabilities needed. In this section I will address how some programs changed their name, reduced their size, manipulated language, responded to market needs and availability, continued

agency ownership, and bought into a new manual or model in order to further illustrate where some people have been led.

- **Changed Name**

In an attempt to be more progressive and to keep up with current trends in the field, programs searched for new titles which would better describe what they said they were trying to accomplish. Titles or names such as The Independent Living Program, Personal Care Alternatives, Individual Service Options, Community Options, and Enhanced Family Living began to emerge. Upon closer examination of some of these "new" programs, not much has changed from the old way of viewing and programming people, except the name.

- **Reduced Size**

Policies around the country on state, local and agency levels began to emerge which stated that all new programs or group homes would be no larger than fifteen beds, eight beds, six beds, four persons, three persons, or two persons. There is a vision of a big "meat grinder" which larger programs are put into; of course what comes out the other end looks different and is smaller but has the same qualities. Again as we looked more closely, size is the only thing that changed in some programs.

- **Manipulated Language**

A new set of terminology has begun to emerge that describes programs as promoting choices, community participation, relationships, person centered services, and individualized programming. Unfortunately, even though some programs have these words written in their mission statements, the reality is that few people have choice, participate in community, have friends, have services built around their needs, and have a program which is not shared with others with disabilities. Even though the language has become more positive, it has also served to confuse what is really occurring for people.

- **Market Needs and Availability**

Programs responding to the need to downsize and close institutions, serve a large number of people, assure support for people with more intensive needs, and acquire accessible places, coupled with the availability of funds to develop congregate housing resulted in the creation of complexes and group living settings which exclusively serve people with a specific disability. Some of these programs continue to operate under the premise that these settings are the most appropriate and cost effective for the individuals living there. The people responsible for these programs argue that they were created to respond to the market needs of the system and continue to be the most appropriate and cost effective available.

- **Continued Agency Ownership**

Agencies have begun to state that they give people an opportunity to have a home of their own. Even though some programs talk of the home as belonging to the person who has the disability, the setting is still referred to by a name other than the person's, the person does not hold the mortgage, the person does not sign the lease,

things in the home are still agency owned, and most importantly, the person does not describe the home as his or her own.

- **New models and manuals**

Once an approach seemed to work for one, two, three, or four people, agencies began believing once again that they had found the answer or the most correct model for providing residential services. Program models such as adult foster care and congregate apartment living with communal supports had become the "perfect program." Again we fell into the trap of believing that one model would fit everyone. Agencies ran out and bought the latest manual and began setting up programs that still had many of the same qualities as the old ones.

It is apparent that the traditional continuum approach to residential services is not working. Therefore, in order to provide support to people with disabilities to live in their communities in accordance with their rights as people and our values as providers of support, we must, in the words of Marc Gold, "Try another way" (Gold, 1980, p. 1).

The following story about Karren will demonstrate what changes can and need to occur in order for people to have the best quality of life while "appropriate care, independence and oversight" is accomplished. Then I will outline the values we will need to take us where I believe we need to go in the future.

KARREN'S STORY

We met Karren and Sharon on the same visit during which we met Jeanne. They lived in the same room and had been roommates for at least 5 years. Karren and Sharon told us that they would be willing to come "check out" Greeley as a place to live if we could guarantee a few things. They said, "We want to live together because we are friends. We want an apartment that has wide enough hallways so that Karren can turn her wheelchair around and Sharon would not bump into things. And we want the people who work with us to be nice."

We returned home with the task of finding an apartment for Karren and Sharon. Our staff called every apartment complex in our city, finally locating a complex that had two accessible units directly across from each other. This complex of 75 units was located on a bus route, was close to shopping, and had friendly apartment managers. We still wondered if Karren and Sharon would like it. Would they mind being in a place that had no other people who had noticeable physical disabilities? Would it be accessible enough for them? Would they like us and our community? Without knowing the answers to these and many other questions, we decided to take a risk and rent the two-bedroom apartment for Karren and Sharon and the apartment across the hall for their support staff.

Karren and Sharon came to visit in August of 1985 and stayed in the newly rented apartment. For 3 days we all worked hard trying to impress each other. Sharon spent

a great deal of time asking us if she was being appropriate, while we worked hard to make them both feel at home, hoping they would want to live in our community.

Two weeks later, Karren and Sharon moved 300 miles to their new community, leaving behind a major portion of their lives and all of the relationships they had developed over the many years they were institutionalized. In a sense, the move was like entering a whole new country where there was a different language and a whole new culture. They were "foreign students" who wanted so much to make it in their new land, at the same time missing what used to be home. The night they arrived, Murphy's Law seemed to be in effect when the person who was to be one of their live-in support people came down with pneumonia. In addition, the primary support person who had been coordinating most of the arrangements was diagnosed with an illness that required her to resign immediately. It was then that we realized that certain basic items were missing from the apartment, including food in the refrigerator and blankets. Everyone, including Karren and Sharon, was scared. The two women were forced to trust that a group of strangers would somehow make things right. K-Mart and Dominos Pizza came in handy and, after one of our staff volunteered to sleep on their floor, we all made it through the first night.

Karren had lived in the institution for 28 years. Her records indicated that her admission had been strongly recommended by her family physician, who felt she would be better off with children her own mental age. She had been described as having severe mental retardation, microcephaly, cerebral birth trauma, prematurity, anoxia, spastic quadriplegia, well-controlled essential hypertension, strong depressive tendencies, problems with constructive criticism and discussing problems without crying. The records go on to state, "Historically Karren's physical handicaps have always affected her self-image. The more Karren has the opportunity to master and be responsible for, the more adequate she seems to feel and behave" (Grand Junction Regional Center, Colorado Division for Developmental Disabilities Evaluation Report, 1986, p. 1).

Karren has a sister and brother-in-law who are very involved in her life. When Karren first decided to leave, they were concerned about her ability to function outside of the institution. Based on what they had been told about Karren, they felt that she had profound mental retardation and could not care for herself in any way. We told the family that their input was appreciated and that our role was both to facilitate Karren's move and to ensure that she received support and assistance for the things she could not do, while teaching her things she wanted to learn. We saw our role as spending time with Karren to discover her gifts, strengths, and talents and assisting her in applying these. At the time, Karren's family still believed that Karren needed to stay in the institution. It was Karren herself who convinced them that she was adamant about taking this opportunity to leave.

Even though Karren's sister and brother-in-law initially were reluctant about her move, over time they have been a major support to Karren. In addition to visits and consistent contact through the telephone and mail, they have purchased furniture

and other items that Karren has needed. It is safe to say that Karren has demonstrated to them and many others throughout the last 5 years that her abilities certainly outweigh her disabilities.

The first 2 years after Karren left the institution were especially rough for her. Even though she wanted to leave and had no desire to go back, she was still sad much of the time. It took a while for Karren to become used to her new surroundings, the new people in her life, the new struggles, and the new challenges. In some ways she felt vulnerable. She was not sure whether this new life was real. Trust for Karren was not instantaneous but developed over time. After living in her new apartment for about 6 months, Karren developed a bed sore on her hip. She became very upset, began to cry, and would not speak to anyone. Finally, Karren told us that she was afraid that because she developed this sore, we were going to send her back to the infirmary at the institution. We were beginning to learn how difficult a move is for people and how difficult it is for people to believe that they can actually have a home.

Karren continually taught us how to redesign our supports in ways that responded to her unique needs rather than the needs of systems or organizations. After about 9 months of being in their apartment, Karren and Sharon asked us to "back off" on the amount of support we were providing. At the time, there was a support person available to them whenever one of them was in their apartment. There was a staff apartment across the hall from their apartment where a support person slept every night. In addition, there was an intercom system in the apartment, which picked up every sound from their apartment and transmitted it to the staff apartment. Essentially, Karren and Sharon were being monitored every minute they were in their apartment.

The regulations under which we received money to support Karren and Sharon specifically stated that support had to be available to evacuate each person within 3 minutes in case of a fire or other emergency. In designing a reduction in the amount of support, somehow we had to adhere to this regulation.

The outcome of this dilemma has been used as an example to demonstrate ways in which people can receive adequate support without having their lives controlled by it. Karren and Sharon learned how to use a speed dialing telephone. The top three buttons were programmed to dial directly to an answering service. When the telephone rang at the 24-hour answering service, a line that was Karren and Sharon's line would light up. The person answering the telephone was trained to pull down off the shelf a procedures book designed specifically for Karren and Sharon and to ask Karren or Sharon what could be done to help them. For example, if there was a fire in the apartment, Karren or Sharon would speed dial the answering service and tell the person about the fire. The answering service staff would then look under "fire" in the procedure book and follow the written instructions (e.g., "In case of fire, first, call the fire department, second call apartment managers"). The apartment managers, who had befriended Karren and Sharon, also agreed to be on contract to

respond to their emergencies. They were trained in fire evacuation by the local fire chief and participated in drills once every 3 months. In addition, they were trained by a physical therapist in transferring and lifting in case Karren needed to be moved quickly. Also, the answering service staff would call an emergency beeper, which was specifically for Karren and Sharon. The beeper was covered by workers who had spent time with Karren and Sharon and was used initially by the two women like a call button when they needed extra assistance. Finally, the answering service was to call an emergency beeper for the residential team that was used for anyone needing their assistance.

Essentially, Karren and Sharon simply reported an emergency, after which well-trained, concerned people who knew them both would respond immediately. The apartment managers, who lived down the hall and had to be there anyway, would be in Karren and Sharon's apartment within 1-2 minutes. In addition, once the alarm was pulled, many of Karren and Sharon's neighbors would also have assisted in bringing them outside safely. Support people who knew them would be on the scene within 10-20 minutes and, of course, the fire department would take over within minutes.

The realignment of Karren and Sharon's support represented a major shift from how we had previously envisioned people's safety. In the past, we responded to people's need for support by looking for a tested model or a package to apply. This time, we looked at what individuals needed and then spent time thinking about how we could meet those needs based on what these people wanted.

The results were far-reaching. Previously, we continually had trouble keeping overnight support staff who did not like sleeping away from their own families, other relationships, and homes. If we asked people to stay awake during the night, we had to find things for them to do which most of the time were only time fillers. Now, we were asking that support people be available only when they were needed. Support money could now be spent more efficiently and effectively on people. In addition to not having to pay overnight support staff, we did not have to pay for an extra apartment or its utilities. The cost differential alone was a major benefit. Only a small amount of money was needed to secure a beeper, an answering service, and a contract with the apartment managers. Most important, Karren and Sharon were able to gain control over their support and gain access to it whenever it was needed or wanted.

Over time, Karren continued to teach us how to see our work through her eyes in responding to her need for support and assistance. A good example comes from our response to Karren's need for assistance in using the toilet in the daytime. Somehow it had been decided that in order for this responsibility to be shared, a different person would have the beeper each day. So when Karren called the beeper, a support staff person would go and assist her. This arrangement continued for about a year until some visitors to our agency questioned what it would feel like to have a different person assisting you to use the toilet each day. Once this arrangement was

looked at from Karren's perspective, it was obvious that we needed to create more responsive supports. Therefore, attendants from a local attendant care agency were hired to respond to Karren's needs. Now instead of up to 10 people assisting her with her personal needs, the number was reduced to two or three people.

Karren again acted as a teacher by serving on an interview committee involved in hiring support staff to assist her. The committee asked her to develop her own questions. One of her questions was, "How would you help me get from my wheelchair into a car?" As expected, the answers were varied. Some people said they would do task analysis, breaking the task down into teachable steps. Others said they would get an occupational therapist or a physical therapist's consultation. Then one person said, "I don't know, Karren, I guess I would have to ask you." Karren looked at the woman, smiled, and said, "That was the right answer. Let's hire her." We did!

Karren has had many joys in her life over the last 5 years in addition to all the challenges and struggles. One of those joys came when she had the opportunity to ride in a hot air balloon. One of Karren's support persons married a man who owned a hot air balloon. Much of the discussion Karren would have with this person centered around ballooning. Karren decided that she wanted to ride in this balloon. Hot air balloons have not been made accessible for people who use wheelchairs, so first we had to overcome this obstacle. Karren herself generated the solution. She suggested that the cushion of her wheelchair be placed on her kitchen chair and that rope be used to secure her in the chair. Of course, the skeptics among the crew did not think it would work, but it did. Karren was lifted into the basket of the balloon by the group who were crewing this flight. Again the skeptics among the crew did not believe the balloon would get off the ground. Well, it did! This ride was to be a tethered ride, which means that there is a rope that is attached to the balloon so that it does not fly away. Karren said, "Detach the rope, I want to fly." The crew once again were uncertain, but the pilot detached the rope and Karren flew. Since then Karren has been a crew member on other flights. She now calls herself a balloonist.

Karren always enjoyed being around children, and many children felt the same about her. With help from some friends, Karren took her first volunteer job with a day-care center. Two years later, she left this job and took a job with a day care center for pay.

In 1989, Karren and her friend Mark, whom she had been dating for 2 years, decided to live together. At first, it was difficult for both of them to gain acceptance of their decision to live together from some family and friends. As time went on, they learned what it was like to be in a committed, romantic relationship, and most of their family and friends came to accept and respect their relationship. As of July 1990, they were planning to vacation together, move into a house, and marry.

THE FIRST STEP: ADOPTING NEW VALUES

There is no one model that seems to work best to support and assist people to live in their homes. What has become increasingly clear to me over time is that our belief system or values, along with our vision for people, are at the core of everything that occurs. Once we understand where we want to go, we can begin to formulate questions around the issue of how to arrive there.

A discussion of values must begin with the most basic of assumptions: all people have the right to live in their own homes with whatever support they need, regardless of labels, skills or lack thereof, or physical appearance. I also believe that there is nothing magical about any building or environment where people lived or live and that any support either currently received or yet to be acquired could be provided in people's own homes. We cannot exclude any person from these intense beliefs.

Although other values contribute heavily to our approach, the above value is considered the core one. This belief and our commitment to it is the primary catalyst for us and for the people we support. Even though we will not always agree on the method, technique, support, timing, or just about anything else relative to the process of supporting people to live in their own homes, there can be few disagreements about this underlying value. It is clear that, in order to provide the opportunity to live in their own homes to people who previously had no such opportunity, we as support persons have to unlearn much of what we had learned in the past and, in a sense, deinstitutionalize ourselves. What follows is a discussion of 18 values that we believe people must adopt in order to effectively and unobtrusively support people to live in their homes. Although there is no real order to these values, for easier reading they have been grouped according to their relationship to beliefs, the provision of support, and the roles of people who provide assistance.

The Desire and Right To Live in One's Own Home

As our residential services developed, we began to believe that smaller is better. The size of a program often became the sole criterion for determining quality and, as a result, it was assumed that a place where two people with disabilities lived had to be better than a place where three, four, five, or six people lived. Furthermore, we believed that the extensive use of an adult foster care model, in which people ages 18 and older lived in a family's home, was preferable to group living. Although this adult foster care model was used for people with all sorts of disabilities, typically it was used more frequently for those people with more severe disabilities because of their greater support needs. The rationale for selecting this option often was that many people never grew up in families, therefore we were providing them with an experience that previously had been denied. In addition, we called these adult foster care arrangements transitional homes, where a person who never before had lived in

the community would gain more of the skills and experiences needed to live in a more independent setting. As we begin to support people to live in their own homes, we are learning that smaller is indeed preferable; however, people really would prefer to live in their own homes. Coming from a large congregate facility either to a small residential program to live with two, three, four, five, or six people or to an adult foster home may be better, but, in most cases, it is still someone else's home.

Finally, the majority of adult foster homes and small residential programs impose rules designed to keep order in the home. Although it may be true that many people in the community at large set up rules for themselves, the major difference is that foster care or residential program rules rarely are set up by the persons who have to abide by them. The question becomes, "How can we support those people who did not grow up in families and who never have lived in communities to experience family relationships and a transition to their respective communities while respecting their right and desire to live in their own homes?"

Ownership Redefined

Although we wanted people to own things such as furniture, stereos, televisions, and, indeed, their own homes, we knew that in most cases this would never occur. Most people we supported lived below the poverty line, which prevented them from owning many things. Even though we knew that it would be extremely difficult for people to own things, we invented elaborate budgeting programs to have people save their money for purchases. It was difficult for people who lived in group living programs to feel ownership of an item they saved a long time for when it was only one item in the place among many that they did not own. In addition, many times our programs took these items away from people as a consequence for what was perceived as unacceptable behavior. People found it difficult to feel ownership in the place they lived in when it was named after a street, agency, or a famous person. For the most part, people had very little turf and territory that was truly their own.

As we begin to assist people to have their own homes, the people define their homes and the items in them as personal territory or turf. Places where people live have to be identified by the person who lives there, for example, "Jack's home" or "Julie's place." This does not mean that people actually own their homes in all cases. In fact, in most cases people have not yet been able to hold their own mortgages. People are beginning, however, to sign their own leases, cosign with a friend or family member, or in some cases, hold mortgages. Under these arrangements, the home clearly belongs to the person, rather than the agency. The person has the key and the feeling of ownership. This is not much different from the feeling of ownership most people experience when they rent or lease a home. The question becomes, "How will the people obtain the support they need while maintaining ownership of their homes?"

Locus of Control

We thought that because people were vulnerable they needed to be watched all the time. In order to ensure people's safety, we thought they would have to be grouped with other people who had similar support needs. People became our projects. We referred to people as "my case load," "my person," and "my client or resident." In our belief that we cared more than anyone else, we tried to make people fit into our idea of safety. As people begin to take more control over their lives, a totally protectionist point of view prevents them from experiencing risks that contribute to their growth. This realization forces us to back off from being parents to the people we are supporting and to begin to "cut the apron strings." We begin to realize that caring about people means that we have to be willing to let go of our control over them. The question becomes, "How can we acknowledge people's vulnerability while respecting their right to take risks?"

People Are Not Their Labels

Jeanne's psychology report stated, "Her major problem seems to be that she has difficulty accepting her limitations." We thought that if individuals had a label attached to them, then there was some special way to respond to or deal with them. We fit people into categories based on the labels attached to them and then devised a package of services for each category. Buildings that specialized in each category were created. The labels people had attached to them were used to justify our programming. What we are learning is that no two people with the same label are the same and that different people respond to different interventions in different ways. Again, we are forced to look at each person as an individual. We must begin to look for ways people can receive support in typical places, as unique individuals, based on their preferences. The question becomes, "How can people receive the support they need based not on their labels but rather on their individual needs?"

Choice of Language

If language indeed is a reflection of our values, we have much work to do in this area. Our language consisted of calling people residents, tenants, clients, consumers, and describing people by whatever disability they were labeled with. In order to further emphasize a person's disability, we began adding descriptors such as the word "really," in front of the labels we invented. For example, we would describe people as having a "really severe disability," or a "really really severe disability." In this example, the severity of a person's disability was determined by the number of "reallys" in front of the label.

Our language relative to the support we provided also has implications for the people we support. Words such as "services," "volunteers," and "standardization" are used to describe certain actions, rather than words such as "supports," "friends," and "variety." We named places in which people lived by the street names where they

were located, such as "the Alder Street House" or the "67th Street House;" by an agency name such as, "the ARC Group Home" or the "UCP Group Home"; or by people who do not live in the house or never had lived in the house, such as the "John Kennedy House" or the "Ronald McDonald House." The final area that should be considered relative to language and people with disabilities concerns one of the laws generated to protect individual rights. PL 94-142 (the Education for All Handicapped Children Act of 1975) includes a mandate for services in the "least restrictive environment" (or "least restrictive alternative"). The very use of the word "restrictive" implies that people must be restricted in some way.

This language served as a way to separate people and create a "them" and an "us". This tone was set by those of us who used these labels with people in our communities. As we begin to assist people to be in their own homes, it is important that we all clean up our language and refer to people and the places where they live by their preferred names. In cases in which we find it necessary to describe people's disabilities, it is much more useful to describe the specific item in detail (e.g., Don does not see, but can discern shadows if the lighting is adequate). In addition, rather than describing a person in the third person, we must use "person first, disability second" language (e.g., Don is a person who cannot see). Our language must imply inclusion and respect instead of restriction and dehumanization (cf. Research and Training Center on Independent Living, 1984). The questions become, "Does the language we use include rather than exclude?" and "How can we change our language to language of inclusion and people first?"

Individualism and Independence

But, of all American myths, none is stronger than that of the loner moving West across the land. Without having thought much about why, we have taken for granted that, on landing, the colonial traveler no longer needed his community. The pioneering spirit, we are often told, is a synonym for "individualism." The courage to move to new places and to try new things is supposed to be the same as the courage to go it alone, to focus exclusively and intensively and enterprisingly on one self . . . There was of course the lone traveler and the individual explorer . . . In history, even the great explorer has been the man who drew others in a common purpose, in the face of unpredictable hardships . . . To cross the wild continent safely, one had to travel with a group . . . When American ways were taking shape, many perhaps most, of the people who were the first to settle at a distance from the protected boundaries of the Atlantic seaboard, traveled in groups. (Boorstin, 1967, pp. 51-52)

We have been taught that the individual can take care of everything and be totally independent. We had set our expectations for where people could live based on how independent they were or how independent we believed they could be. People were put in a double bind: either they were independent or they received total care. We thought that if people could not be totally independent they would not accomplish much in life. Our goals were goals of independence. Our programs are even called "independent living" programs. People are forced to live in places that coincide with their degree of independence. As we begin to acknowledge that no one is completely

independent, we are forced to give up on trying to make people independent and instead begin to focus on all people as interdependent. Success is no longer defined as people achieving independence. We begin to look at how people can be with others while accomplishing their goals. Rather than, "How do we make people independent?", the question becomes, "Who can be brought together to assist the person to accomplish tasks, skills, and activities, or to make dreams into realities?"

Definition of Individual

We invented individualized habilitation, service, and program plans in an effort to focus on the individual. To make it easier we standardized the forms and, in essence, the plans. To make them even easier to gain access to we invented computer programs with the individualized plans on them. We could literally push a few buttons and produce an individualized plan. Furthermore, we believed that if we treated people as individuals, with this individualized programming we could put those individuals with the same plans together in the same living arrangement. Thus came the rules stating that no more than 15, 8, 6, 4, 3, or 2 individuals could live in a particular setting. As we begin to assist people to live in homes of their own we must truly focus on one person at a time. A plan that focuses on what individuals want for their futures must be developed with them included. No preplanning will work because the person must be at the center of the plan so that the plan is built around him or her. Although sometimes useful in preventing people from being grouped, setting limits on how many individuals can live together has given license to service providers to put together people who do not know or care about each other. If formal direction is necessary our preference would be to set a rule stating that no more than one individual with a disability can live in a home unless two people with disabilities specifically choose to live with each other, and even in this we must be certain people are not making this choice based on limited life experience. For reasons of inclusion and the stated preference of many people with disabilities, we would recommend that no more than two people who have disabilities live in the same home, except in rare cases. The question becomes, "How can we avoid grouping people with disabilities and truly support *individuals* to live in their own homes?"

Reliance on Models

Over the years many universities and agencies and some individuals have found methods or techniques for assisting people with disabilities to acquire greater ownership of their own homes. In some of these cases, a demonstration or pilot project was developed to test this new knowledge. After the project was finished a model was developed and a manual was written. We were always looking for the best model. When we found the one that looked best we tried to make people fit it. Again, we fell into the trap of trying to fit people into something that was predetermined. As we begin to support people to find their own homes, we have to acknowledge that, just because something works for someone else, it is not necessarily going to work for everyone who appears to be in a similar situation. We

have to realize that there is nothing that works all the time. The answers come from asking questions of the person and those who care about that person most and not from models. What models can do is assist us in identifying the questions to ask, variables to consider, and approaches to try. The danger in using models is that they may be used as solutions to complex questions instead of guides to assist us in formulating our questions based on the uniqueness of each individual. The questions become, "What are the things we need to know about individuals and their community to develop the supports they need to be in their own homes?" and again, "Whom should we bring together to assist these individuals in finding the answers to their questions?"

The Readiness Model

We thought people needed some prerequisites before they would be able to live in their own homes. In fact, we purchased and developed an assortment of curricula to teach people everything they needed to know to live in their own homes. Our intention was to prepare people for everything they would have to know before they would have to know it. People were forced to pass some sort of test on our curriculum before we permitted them to move ahead. Moving ahead refers to the continuum mentioned previously, which had different places designated for each block of the curriculum. People were expected to refine their skills in each new place, where the rules of the game and the players all changed. As we begin to give up the idea that people must have a certain set prerequisites before they can live in their own homes, we are realizing that many of the things we were requiring people to do or learn are not done by individuals who currently live in the community. Rather, people in the community often have someone else do these things for them. For example, some people have others clean their houses, cook their meals, or balance their checkbooks. In addition, we learned that individuals in communities are willing to offer assistance to people in ways that render some of our prerequisites inapplicable. The question becomes, "How can we support people to learn what they want to learn while assisting them to receive support for things that they would like or need others to do for them?"

Focus on What People Can Do

As with many residential programs, the majority of our testing focused on what people could not do. We learned many things about what skills and experiences people did not have. People were put under microscopes, and we searched for everything they were missing. We became so disability focused that we invented elaborate services to respond to all we found. Residential settings were designed to respond to people's perceived weaknesses. We further justified our groupings by putting people together with people who had similar perceived weaknesses, whom we identified as peers. As we start to focus on what people *can* do, many of the things they could not do become insignificant. The process of scrutinizing may continue to occur, particularly with people who perplex us the most. However, concentration must be on people's abilities and strengths. We must ask people what

they wish to learn. The question becomes, "How can people express their gifts, abilities, and talents while receiving whatever support they may need?"

Useless Programming

In an attempt to ensure that people receiving residential services from a human services agency were learning something, we required them to be programmed. This meant that we attempted to find things that people did not know or needed to improve upon. We also found behaviors that disturbed us or others and embarked on training programs to alter the targeted behavior. Because programming was required to be behaviorally oriented, (i.e., measurable and observable) we had extensive documentation and developed graphs and charts. People became our "subjects" in an experiment we were calling "active treatment." Simple things like learning to brush one's teeth were relegated to this programming, resulting in many steps that were all measurable and observable, complete with documentation, charts, and graphs in color. Most of the time this programming was based not on what people wanted or desired, but on what was required or desired by others. It was focused on the person's disability or difference, or on eliminating his or her struggles. As we begin to support people to live in their own homes, we must focus on their abilities and uniqueness and offer them understanding for their struggles. We must offer assistance to people to reach their personal goals for a positive future, rather than programming for often useless tasks that contribute little to a meaningful life. If people want or need to learn something, we can offer this information in the spirit of true education. This learning can take place where it makes sense for the person to learn and in a dignified way. The question becomes, "What do people want or need to learn, and how can we support them to learn these things in their communities and in ways that respect their choices and preferences?"

Simulated Residential Environments

Along with the idea of readiness comes the notion that, if people could not live in places that were homes, then somehow it was alright to have them live in places that were *homelike*. Programs then proceeded to put people in places that were not homes by anyone's estimation, but were similar to a home. We put pictures on the walls that were not of the people who lived there, called rooms in the house typical names like family room, and located these agency-run and owned places in typical family neighborhoods, ignoring the fact that nobody in the neighborhood (including us), believed this was a typical home. As people begin to live in their own homes, they are doing things like putting their own pictures on the walls, naming the rooms whatever they please, and living in real homes in family neighborhoods. In the latter situation, people have a much better chance of being involved as a member of their neighborhood. The question becomes, "How can we ensure that we are supporting people to live in *real*, not simulated homes?"

The Myth of 24-Hour Supervision

As people with more intensive support needs were beginning to leave large congregate facilities, we believed that they needed someone to be with them 24 hours a day. Consequently, many rules, regulations, and standards were set up to ensure that any person for whom it was determined that 24-hour supervision was needed received it. How it was determined that people needed this much supervision often was unclear but usually was related to their ability to physically or cognitively respond to an emergency, or to a staff person's fear that these people would in some way hurt themselves or others if left unsupervised. This determination was often made subjectively by overprotective, temporary workers. The result was that people who purportedly needed a high level of supervision were required to live in a place where 24-hour supervision could be provided. In order to make this financially feasible and serve a greater number of people, we tended to group people with more intensive needs together. When we somehow managed to avoid grouping people together, a paid support person was attached to people at all times.

These 24-hour supervision requirements continue to be used by governmental and private agencies as a way to justify people having to live in large facilities, with groups of people who have disabilities, in small residential programs, under constant supervision, or in an adult foster care arrangement. As we begin to support people to have their own homes, we are learning that very few people, if any, need 24-hour supervision. Rather, many people may need 24-hour access to certain supports. For example, some people may need access to support while sleeping. Some individuals may need a form of support in the middle of the night such as being turned or receiving medication. As demonstrated by Jeanne, this support can be provided in the persons home when needed.

We must break away from the practice of responding to people's support needs only with a paid person attached to the person at all times. We are beginning to use simple technology such as push button telephones, beepers, computers, switches, intercom systems, and tape recorders to respond adequately to our previous concerns in supporting people with more intensive needs. In addition, when technology will not satisfy our support concerns, or if it is preferable to engage a real person to respond to a person's support needs, we are beginning to enlist the assistance of neighbors, friends, relatives, and roommates. The question becomes, "What combination of organized technology, informal support, and formal support will be necessary to ensure that a person's support needs are met and personal preferences are respected?"

Focus on What Is Important to Individuals

We thought that there was one right way to prepare people to live in the community, so we concentrated on what our curricula, models, and regulations told us was the right way. We were so busy teaching people everything we thought they needed to know that we ignored what was important to them. Our focus for people became what was important to we professional overachievers, to the program, to the agency, and to the state or federal funding sources. We believed that what was important to all of us would ultimately be important to the person. As we begin to assist people to live in their own homes, we must discover what is most important to the people we are assisting. Once we discover what is important to an individual, we must support that person in working toward those goals or dreams even though sometimes they may be difficult to fulfill. The question becomes, "What will it take for individuals to attain what is important to them?"

Role of Relationships

We always knew that relationships were important to people, but we believed that people wanted to be around other people who could not do things they could not do. Many of our efforts centered around setting up situations in which people could be with others who also had disabilities. We spent very little time assisting people to continue old relationships or to establish new ones. In the past we avoided assisting people to reestablish contact with people they knew from certain experiences in their lives such as institutionalization. As we begin to assist people to live in their own homes, we must realize the importance of relationships in people's lives. Renewing contact with people they have known throughout their lives can be extremely important. We must assist people if they wish to renew contact with individuals from their past, whether they are paid assistants, or previous roommates, or any other people who have disabilities. Assisting people to renew contact with family if they wish also can have a positive effect in people's lives. The questions become, "Who are the people in the person's life with whom he or she may wish to reestablish, maintain, or increase contact?", "Who are the people with whom the person would like to be in a relationship?" and "How can these relationships be facilitated?"

Roles of People Who Provide Assistance

People who provided assistance in a sense were asked to be surrogate parents. We asked these workers to treat people like their children. Our job descriptions stated that staff people were responsible for making sure everything was in order in the person's life during their shift. When their shift was over, the next person would take on the same role. Unfortunately for the people receiving these services, the turnover of these surrogate parents was extremely high. Consequently, many times young, untrained, and insensitive staff were hired to fill gaps in our shifts. In addition, we hired specialists to help us figure out our treatment plan for the person

or group of people. These people typically specialized in "pieces of people" without paying much attention to how their recommendations affected other parts of the person's life. For example, a speech therapist who recommends that a person learn sign language while in speech therapy may fail to consider that no one with whom the person comes into contact knows sign language. Under this system many of our employees never had the opportunity to come to know the person with whom they worked. As we begin to assist people to live in their own places, the people who provide support must become facilitators, ensuring that people receive the support they need by coming to know them. For example, those who now provide assistance are spending time coming to know the person's desires, wants, needs, dreams, and aspirations. In some cases, the people providing direct assistance are obtaining critical information through contact with people who consciously take the time to come to know the person well, such as family members, friends, neighbors, and others. Relative to the roles of support persons, the question becomes, "How can the people providing assistance redefine their roles in ways that will give them an opportunity to come to know the person's desires, wants, needs, dreams, and aspirations, based on what they discover about who the person is?"

Shared Responsibility

As previously noted, we spent a great deal of time figuring out what people did not have and then created positions for staff people who became experts on people's needs. We expected these experts to have all the answers. The notion of rugged individualism mentioned earlier also applied to the people who provided the assistance. Both by design and by identifying people as experts, we made it difficult for them to work together with those who also were interested in the person. When interested persons did come together, it was in times of crisis which required expert intervention or in an annual meeting in which all the experts were expected to have expert reports and expert opinions. As we begin to support people to live in their own homes, it is essential to coordinate and manage support with the people themselves and those who care about them on a regular basis. Essentially, to coordinate efforts to support individuals to live in their own homes, a team, is formed, which includes those people considered "experts," those who provide indirect or direct support, and the individuals themselves. The role of this team is to negotiate with the individuals themselves and the providers of support to determine what supports are needed and at what level. The team also serves as a back-up when needed in some part of the support. The question becomes, "Who are the people who form a "team" or "circle" around this person and how do we involve them?"

Accepting Responsibility for Mistakes

When things went wrong or did not work as planned, we blamed the people we claimed to be supporting. What did not work, of course, was the fault of the person with a disability. To describe people's responsibility for the failures we perceived in them, we said they were unmotivated, lazy, or incompetent. As we begin to assist people to have their own homes, we are realizing that the systems that have

excluded people from their communities and neighborhoods are to blame for what does not work rather than people's inadequacies or actions. The question becomes, "How can we as providers of support take responsibility for system failures and remove system obstacles?"

These value statements are by no means exhaustive. They do serve to guide us as we begin to support people to live in their own homes. There must be a clear set of values that drive us to action. From these values and vision comes our commitment to support people to take a valued place in community life. Throughout this section a series of questions have been posed in order to address each value statement properly. My intent is not to answer these questions directly, but to facilitate thinking and discussion on how their answers will affect each individual situation. critical questions.

Commitment is what transforms a promise into reality.

It is the words that speak boldly of your intentions and actions that speak louder than words . . .

It is the making of time when there is none.

Coming through time after time, year after year after year . . .

Commitment is the stuff character is made of; the power to change the face of things . . .

It is the daily triumph of integrity over skepticism . . .

(Kovensky, personal communication, 1985)

4. Are state and local governments charged with protecting the safety and well-being of people with mental retardation and developmental disabilities adequately overseeing small group, community based housing programs?

This is a difficult question to answer for two reasons. First, some state and local governments do a better job than others of protecting the safety and well-being of people with disabilities and adequately overseeing small group, community based housing programs. Second, the word "adequate" is subjective and difficult to define. Furthermore, many state and local governments certify people's homes and in the process certify agencies providing the services. Therefore, it has become a requirement that the person and their home have to meet the standards set by the agencies.

By whose standards do we measure this adequate oversight? What is the margin of error we will allow? As has been addressed in this testimony, by grouping people with disabilities we make it very difficult to assure the safety and well-being of individuals without compromising quality of life.

We have been unsuccessful in the past in guaranteeing the health and safety of people with mental retardation and other developmental disabilities living in large congregate facilities, and we have begun to question this capability in smaller group community based programs. Unfortunately, many state and local governments have a difficult time guaranteeing the safety of all their citizens all of the time. Our best

chance of being successful at this will be assuring that those people closest to a person advocate for them.

As we think about quality assurance we need to ask "what is a true measure of quality for a particular individual?" Each of us if asked this question may have a different answer. Clearly we need to be concerned about the quality of people's lives, particularly for those people who are more vulnerable to abuse. Instead of trying to create a standard means of assuring quality, we will be more successful if we consider what it would take to assure that each person's personal quality of life is protected. In order to assure the safety and well being of people with mental retardation and other developmental disabilities, quality assurance will need to be broken down into two categories: quality of care and quality of life.

• **Quality of Care**

Quality of care includes such areas of concern as: fire safety, medical and health considerations, nutrition, victimization, missing person, severe weather and natural disasters, home maintenance problems, community and pedestrian safety, and provisions for back-up and extra assistance. Typically state and local governments have responded to the need to assure quality of care by setting standards and regulations that all people under particular funding categories have to follow. People are then subjected to standards which unduly restrict them or do not adequately meet their needs. Many times an individual's health and safety are dependent upon the interpretation of a set of regulations and standards which have been developed for a group or particular category of people. However, every individual has different needs different supports to assure their health and safety. Furthermore, people who provide the supports often develop "packaged" ways to meet the standards so that many people receive supports according to "model" approaches.

People around the country are beginning to look at quality of care from an individual perspective. Essentially, an Individual Safety Plan is developed for each person which reflects a recognition of the uniqueness of each person's capacities and needs, as well as the particularity of his or her living circumstance. As a single document, the Individual Safety Plan more appropriately addresses the unique health and safety needs of a person than global plans intended for a particular category of people with disabilities. The Individual Safety Planning process assures that an individual's control, choices, preferences, needs, and capacities form the basis from which support is provided.

These plans would be written and approved with the person and all the people closest to them including family members, friends and neighbors. State and local oversight would consist of a review of these Individualized Safety Plans to determine whether or not they were adequately meeting the safety needs of that particular individual and that people responsible for provisions in the plan were following through on their commitments.

• **Quality of Life**

In the past we have spent so much of our time on issues of quality of care that we have neglected what people have described as true measures of quality. Essentially this has to do with subjective areas such as who are the people in a person's life, what places they share with other people in their community, how they are respected by others, what decisions they make for themselves and what they are doing to personally develop their abilities, gifts and interests in order to grow as individuals.

It is my strong belief that we cannot regulate or mandate the improvement of quality of life. As mentioned previously, every person defines his or her quality of life differently. Therefore, in order for us to assure the quality of life for people who are more vulnerable to abuse we will need to determine how each individual defines their own personal quality of life.

To accomplish this we will need to develop Personalized Plans which address these critical life issues for people. These plans must be developed and monitored by the individual and all the people who care about them including family members, friends, neighbors and personal assistants.

State and local government oversight would be one component of a team of people who would offer technical assistance versus monitoring compliance. The team would be made up of people with disabilities, family members of people who have disabilities, advocates of people with disabilities, agency providers and representatives from state and local governments. Their role would be to offer advice on ways to improve on the quality of life of the particular individual. This would serve three main purposes: one, it would get all the people who are concerned about a person working together to improve the person's quality of life. Two, it puts the issue of quality of life in the hands of individuals in local communities who clearly know people better. Three, it offers critical hands on training to people providing assistance on an everyday basis to people with disabilities.

5. Please comment on the growth of the provider community and whether multi/state and multi/home providers can effectively meet the needs of people with mental retardation and developmental disabilities?

The most effective supports that individuals with disabilities receive are from people who know them and their communities best. Providers should be based in the local communities where supports are being provided and be small enough so that decisions which effect people's lives are being made by those who know the individuals on a personal basis.

The more knowledge providers have of the community in which services are being provided, the more likely it will be that they will find ways of assisting people with disabilities to be included in that community. Therefore multi/state and

multi/home providers can be most effective if the people who are managing the agency on a day-to-day basis are present in the community where service provision occurs. Furthermore, providers need to be small enough so that the day-to-day agency managers are personally familiar with each individual who receives their services.

As we move toward assisting people to live in their homes it will be critical that providers assist people to have more control over their lives and to become active and productive members of their communities.

6. Is the growing community of providers for people who have mental retardation a cost effective plan for housing, training and providing for people who have mental retardation and developmental disabilities?

Clearly research on cost is showing us that smaller, less regulated, and more individualized residential alternatives are costing less. Numerous studies have been conducted that compare the costs of community residential facilities (See Baker, Seltzer, & Seltzer, 1977; Heal & Daniels, 1978; O'Connor, 1976; O'Conner & Morris, 1978; Templeman, Gage, & Fredericks, 1982) or have compared the costs of public institutions with that of community residential facilities (See Mayeda & Wai, 1975; Minnesota Developmental Disabilities Planning, 1982; Nihira, 1979; Wieck & Bruininks, 1980). There have been none that have looked at person-controlled options. However, the cost of community-living arrangements, typically in the form of group homes, were less expensive than the cost of institutionalization. In the Pennhurst follow-up study, Conroy and Bradley (1985) indicated that the difference in costs could be related to the fact that those individuals residing in Community Living Arrangements could utilize services such as church, library, and fire safety that were available to others in the community, thus reducing the expenses. Also, community programs tend to use a "generalist" approach, where the staff perform a number of responsibilities instead of only one specific task, as occurred at the institution. Finally, there appears to be little relationship between the individual's needs and the cost of the Community Living Arrangement. Rather than developing placements based on need, people were more likely to be placed in a residence based on availability. Conroy and Bradley noted that this system of placement is contrary to the intent of the court-ordered deinstitutionalization. Additionally, the cost data on group living arrangements are not indicative of costs associated with person-controlled housing because the housing costs have not been separated from the costs of providing support.

The Medicaid Waiver has been the most significant contributor for funds for community services. In 1982, Bruininks, Kudla, Wieck, and Hauber reported that among 2,000 community residential facility directors, 46% cited the lack of comprehensive individualized services as a major problem in community placement. Nerney, Conley, and Nisbet (1989) analyzed the costs of providing community living services in Nebraska, New Hampshire, and Michigan. They analyzed three service regions in their entirety and concluded that the least

expensive option was family care. However when community residences were compared, the authors found that the costs, in general, are higher when persons with severe disabilities are grouped homogeneously. That is, if persons with severe disabilities are placed together, the costs are greater than when they live with persons with less significant disabilities or in a individualized living arrangement. Further, Braddock, Howes, and Hemp (1984) explain that 90% of federal dollars are expended in large mental retardation/ developmental disability programs that serve only 5% of all persons with developmental disabilities.

In January 1991 New Hampshire closed Laconia State School, its only state institution for people with mental retardation and other developmental disabilities. This move made New Hampshire the first state in the nation to provide only community based services for people with mental retardation and other developmental disabilities. Cost data from this state is relevant to your question. In 1990 before Laconia state school closed the annual cost per person was \$103,000. This \$103,000 was billed for each individual and was not based on the level of services they received. In 1992 the state provided services to 1,100 people through Medicaid's Home and Community Based Waiver at an average cost of \$46,000 per person. All of these individuals meet the same criteria as persons receiving ICFMR and Institutional services. In addition, the state provides services to 58 people in seven ICFMR's at an average cost per person of \$96,725 and they purchase the services of a Private Pediatric ICFMR for 23 children at an average cost of \$59,000 per person.

7. **What sort of diversity should state and local mental retardation and developmental disabilities programming strive for in order to provide people with mental retardation and developmental disabilities the greatest number of appropriate housing options?**

As has been stated in many different ways in this testimony, people with disabilities want, deserve, and have a right to receive support to live in homes of their own. Diversity will not come from perpetuating the old continuum of services by adding more rungs on it. Instead, state and local governments will need to strive to devise ways to be flexible enough to provide people with housing and support options which are tailored for each person. The most appropriate housing options will be those that reflect the person's needs and desires.

A person's housing must be separated from the support they receive. There is nothing magical about any building, facility or house that people live in. As has been discussed, people can receive support in any home they choose. Service providers must maintain the flexibility which is critical in offering as many choices for housing and supports as there are people who seek them.

Perhaps the best answer to this question are two questions I posed to you in the first pages of this testimony: What would you want your life to be like if you had a developmental disability? and Does the American Dream hold true for all of us?

To conclude, the above discussion of values has served to remind us that our beliefs must drive our actions. Before we can assist people to live in their own homes, we must first truly believe that people can and should be living in homes of their own in their neighborhoods and communities. People as "part of" rather than "separate from" is the common thread through all these values.

Contrary to what Hollywood shows us, all people go through highs and low periods of struggle throughout their lifetimes. The struggles are real and can at times be extremely difficult for people who have disabilities. In the past we tried unsuccessfully to eliminate the pain in the lives of people who have disabilities by setting up simulated settings where they would be protected from life's struggles. According to George Ducharme (1990) we now must, "Walk with people instead of working with them." This means that we live with people through life's ups and downs instead of trying to eliminate them artificially. People's lives do change over time, but it is important that we walk with them through the times of struggle.

Finally, the issues discussed in my testimony challenge us to look at our roles differently. They suggest we become *facilitators* of a process designed to bring people together to assist the people whom we support to obtain what they want. As we examine these issues deeply, we focus away from them as being disability issues and consider instead how we can create a world in which all people belong and have a place they can call home.

"Home is the place where, when you go there, they have to take you in" (Frost, 1939, p. 53).

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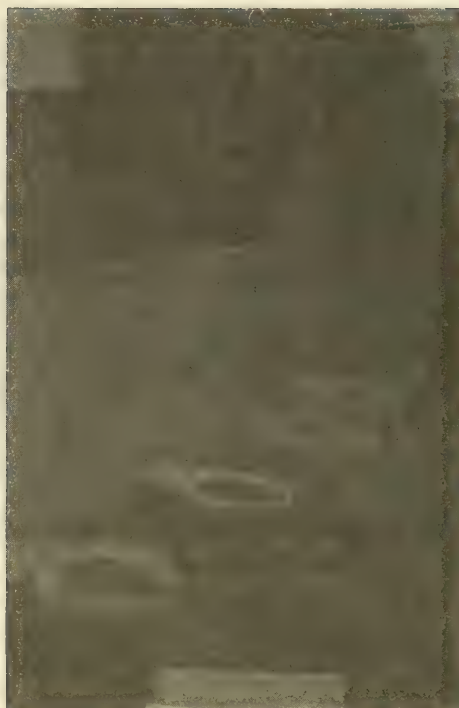
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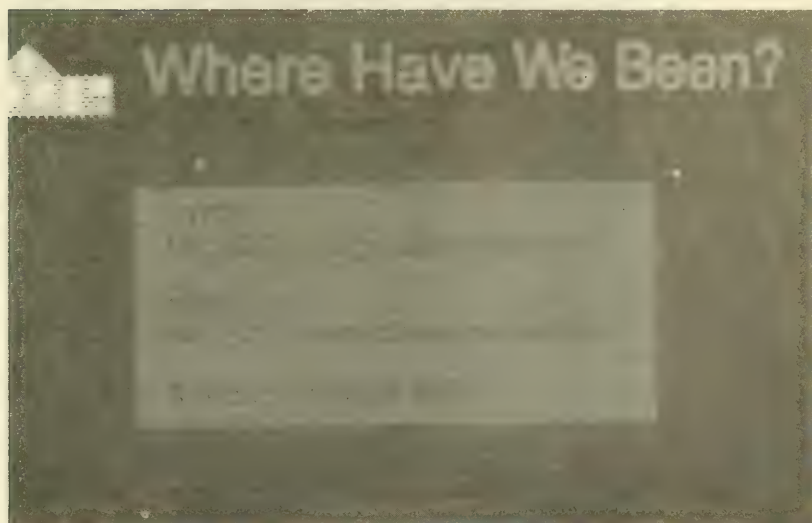
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American Federation of
STATE, COUNTY, and MUNICIPAL Employees
 AFL-CIO

INDIANA AFSCME COUNCIL 62

1422-24 N. PENNSYLVANIA STREET, INDIANAPOLIS INDIANA 46208

PHONE 632-1432 - AREA 317

April 20, 1993

The Honorable Ron Wyden
 United States House of Representatives
 1111 Longworth
 Washington, D.C. 20515

Re: Subcommittee on Regulation, Business Opportunities and
 Technology - Residential Programs for the Mentally Retarded.

Dear Congressman Wyden;

I read with great interest your subcommittee's recently released report on residential programs for the mentally retarded. The report highlights in dramatic fashion many of the real abuses which exist as we have deinstitutionalized and profiteered our mentally and psychologically ill citizens.

Unfortunately, the state of Indiana is attempting to move our mental health system towards an even more decentralized structure, without any adequate oversight and in spite of the numerous inadequacies documented in your report.

One particularly glaring example of the abuses which exist in Indiana is Park Center a community mental health center in the Fort Wayne area. In one small mental health center, virtually all of the problems you documented in your subcommittee report exist and recently have come to light. These include unaudited books, alleged double payments, lack of accountability, and even worse, several recent deaths both among in and out patients at the center.

I thought you and your staff may be interested in some of the recent articles that have been appearing, almost weekly. If you have any questions or need any additional information, please do not hesitate to contact me.

Sincerely;

Stephan Fantauzzo
 Stephan Fantauzzo
 Executive Director

SF/le

enclosures

cc: Jill Long

Critics rip Park Center service

Mental health facility's priorities draw fire

By RON FRENCH
and BRIAN HOWEY
Staff Writers

It was late October 1991 when Sandra Hiedorf headed down the hallways of Park Center to ask for help.

Hiedorf had severe paranoia, and she believed that the mob was trying to kill her two children.

A week earlier, court records state, she'd bought a gun so she could kill her kids before the mob could murder them.

But the dealings of her son, Stanton Hiedorf, the 45-year-old walked into Park Center, Inc.

After a brief visit with a psychiatrist, she was given a shot of medication and sent home.

Within two days, on Oct. 26, 1991, Stanton Hiedorf was dead, a bullet in his head, and his mother was in jail charged with murder.

In the year preceding the Hiedorf case, two people committed suicide, a third molested a child, and a fourth started an arson that caused \$150,000 in damage and injured three firefighters.

All of these incidents occurred at Park Center, 909 E. State Blvd., a facility that received more than \$7 million in tax money last year to provide psychiatric services.

None was admitted to the center's 12-bed acute care facility, the Mental Health Association said.

But the center declined to discuss any specific cases.

Though the center might not be legally obligated to treat every acutely mentally ill poor person, critics say the center's government financing allows it to do more.

Park Center has received \$95.5 million since 1976 from Indiana, the federal government, Allen,

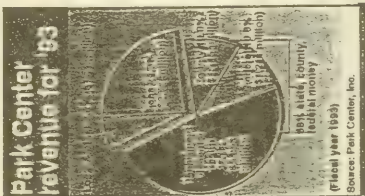
Adams and Wells counties. "We all have a responsibility," Park Center board chairman David Lundy said.

"But none of us are required by law to go above and beyond the call of duty," he said.

The center's critics say something must change, or the hospital's care for the community's mentally ill will be choked off.

Though local critics in the mental health field say Park Center is improving, they charge Park Center talks those seriously mentally ill patients who don't have insurance, when Park Center is the only facility in Allen County that receives tax money to care for these people.

■ Fails to meet one of the minimum requirements for receiving millions of dollars in government aid. See PARK CENTER / Page 6A.



Director's \$102,750 salary outpaces most in his field

By BRIAN HOWEY
and RON FRENCH
Staff Writers

Dr. James McKee, president and chief executive officer of Park Center, makes \$102,750 running a nonprofit agency that gets two-thirds of its funding from government sources.

A national mental health expert says that is excessive.

But when the \$77,200 Gov. Evan Bayh asked for McKee's pay, it was more than the \$80,002 made by Bob Dyer, director of Indiana's Division of Mental Health.

E. Fuller Torrey, a national expert on care and services for the seriously mentally ill, is sharply critical of McKee's salary as well as of Park Center itself.

See SALARY / Page 6A.

"I've never seen a community mental health center that is paying an executive director in that range," Torrey said.

"That's private-sector pay in a public-sector setting."

David Lundy, chairman of Park Center's board of directors, defends McKee's salary, saying it is comparable to others in comparable positions.

"We think Jim McKee has done a terrific job keeping his finger on the pulse of the industry," Lundy said.

"It's a lot of money, especially for social workers. It's a very sensitive about it (publicly about his salary). There's a lot of people shooting at him, and they're shooting at Park Center itself."

Bosnian president says talks suspended

2-year hike urged in age for Medicare

By RICHARD L. VERNACI
Associated Press



6A The Fort Wayne Journal-Gazette • Sunday, January 10, 1993

Few beds at Park Center

There are fewer beds for its service population at Park Center than at almost any other center of its kind in the state. Here are some examples:

COMPREHENSIVE CENTER	SERVICE AREA POPULATION	BEDS	PER 100,000
PARK CENTER (Fort Wayne)	358,000	12	1/29,833
BOWEN CENTER (Warsaw)	125,000	18	1/6,944
QUINCO CONSULTING CENTER (Columbus)	162,773	22	1/7,398
SOUTHLAKE MENTAL HEALTH CENTER (Merrillville)	185,000	23	1/8,043

Source: Mental Health Association

Park Center

From Page 1A.

money each year by not offering 24-hour emergency care.

■ Offers fewer beds for inpatient treatment than almost any similar center in the state.

■ Pays Executive Director James McKee \$102,750 a year in salary and benefits, far more than the salaries given directors in similar facilities.

■ Park Center officials say the facility is doing all it can within its budget, and boast that Park Center is one of the best community mental health centers of its kind in the nation.

■ Job Dyer, the director of Indiana's Division of Mental Health, the state's largest mental health financing program, says Park Center officials are "as much victims as villains."

The state has not forged a consistent policy and budget to deal with increased demands for mental

inly ill found that half the nation's 575 comprehensive centers might be violating federal law by operating as for-profit entities or not providing the minimum services required by the program.

In a number of articles and books, Torrey targets one of Indiana's comprehensive centers for special criticism:

Park Center.

The suggestion their facility is one of the worst in one of the worst states.

He has also attacked the health care research division of the state group Public Citizen, is far from

moiry.

"It was like a mom-and-pop store finally became Scott's McKee quipped.

Within a year, the center conducted a sprawling facility on East

Street and increased its staff from 35 people to 250.

The center has become one of the 10 largest in the nation in population served, with branch offices

Charter Heaton, a private, for-profit psychiatric and consulting center at 1720 Heaton St., cannot afford to pay, charges that

they'll have to wait two weeks for an appointment at Park Center," said Bob Kwech, executive director.

The same pattern occurs in the psychiatric units of Fort Wayne's psychiatric hospital, which cannot afford to pay, charges that

Letch, executive director of Lindenview Regional Behavioral Center, the psychiatric center at Park

view.

We get inpatient overflow (from Park Center) all the time,"

On an average day, 25 seriously mentally ill patients are in beds in Fort Wayne. Fewer than half are at

Park Center.

The rest, an average of 13, are at Lutheran and Lindenview.

Park Center officials, Letch said, "let this population be in the way of the rest of the community has been good."

"I'm not sure that will continue."

The seriously mentally ill are almost always indigent, Letch said, and illness makes them unemployable, and they lose their insurance.

Of the more than 8,000 people who sought services at Park Center last year, 86 percent made less than \$20,000; 34 percent made less than \$5,000.

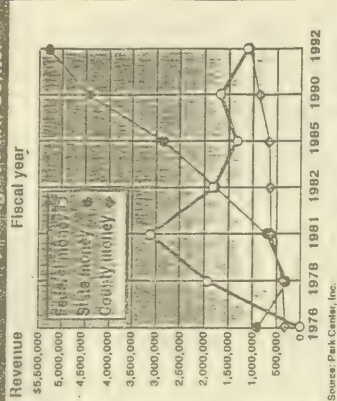
Those referred to Lindenview and Lutheran from Park Center are as poor, if not poorer.

Statistics provided by Park Center show that in 1992, only 16 percent of the patients Park Center treated in its inpatient unit were

packets or through insurance.

That figure looks good compared with the indigent Park Center

Government Funding of Park Center



Source: Park Center, Inc.

Total government funding 1976-1992 for Park Center

United States	\$29,869,788
Indiana	\$40,601,955
Allen, Adams and Vanderburgh Counties	\$12,727,833
Total	\$89,548,787

Source: Park Center, Inc.

October 1988 that Cited Juvenile Probation Officer Ken Watson

drove him to Central State Hospital in Indianapolis, handcuffed him to a chair and left.

"The way it (Park Center) was set up, I guess you'd have to say it was terribly by design, truly

problem lies with the state mental health, which has been kind of

wisely, why? They've gone

Psychiatric care at local hospitals



...and can't get anyone to stay for more than a year. There's no money to pay them and no money to pay the staff. The state doesn't monitor in comprehensive centers to see whether they're doing what they're getting paid for," said Dyer, director of the state's mental health division.

Park Center officials dismiss charges that the center isn't accountable for its financing. "We're not going to release detailed budget figures to the public members because those members won't do the same for their organizations."

"There's always going to be someone who thinks you aren't spending your money correctly," Bonser said.

"We're all have their own interests," he said. "The interests that sometimes get lost in the shuffle are those of the indigent mentally ill, Larson said. "We're all paying for it," she said. "Our community is paying in every way."

Changing attitudes

The legacy of the Itedof case might be changing attitudes at Park Center, Larson and several others said.

A year ago, the first question Park Center would ask about a person in need of psychiatric care was, "What kind of insurance do they have?"

"Now, the first question is, 'What kind of care do they need?'" Larson said.

"We've moved down everything we were doing," McKee said. "One (death) is too many."

While he described Itedof's tragedy as an isolated incident, "We try to guard against that one-in-a-million incident. We went back and looked thoroughly to see if there was anything we should have done."

At the state level, changes finally may be under way to clamp down on centers that aren't meeting the needs of the indigent mentally ill.

Dyer said the attitude at Park Center and other comprehensive centers in the state needs to change.

...of those patients could pay. ...Larson, executive director of the state's mental health division, said that the state's preventive centers try to move patients as quickly as possible to group settings. It's beneficial in the patient and it's cheaper. Yet centers serving much smaller populations have more inpatient beds than Park Center.

McKee and Lundy believe the 225 beds in Park Center's group houses and apartments — nearly all serving indigent clients — would bring that ratio down.

Led in group houses, however, don't address the issue of care for the acutely mentally ill, said former Allen Superior Court Judge Robert Altes, who presided over the informal commission.

"You don't put an acutely ill person in a group house," Altes said. "With 12 beds, they just don't have the facilities for all of that."

The acutely ill person often begins, "When they start feeling better, they don't like to take the medication because of the side effects. So they stop and the next thing you know, they are standing out in the street directing traffic," Altes said. "Then they have to go into a psychiatric ward or the new rehabilitation care weeks."

Where's the money?

How much can Park Center do with its financing?

That's the question that has been asked repeatedly by members of



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Lowest bed ratio

According to statistics compiled by the Mental Health Association, a mentally ill patient has less of a chance of getting a bed at Park Wayne's comprehensive center than in almost any other community in Indiana.

Park Center has only 12 beds to serve the needs of the acutely mentally ill, compared to 353,000. That's one bed for every 29,833 residents.

group houses and a 95-bed outpatient living program. Park Center also operates halfway centers for children and its equivalent for older children, New Directions.

Park Center has an after-care program that draws praise from the mental health community, and serves 3,000 people who are emotionally disturbed children each year.

At a time when millions of tax dollars were pouring into the center, the center was turning its attention to what those in the mental health profession call "the worst of the worst."

The center printed brochures and paid for TV commercials to draw programs for people suffering from "procreatinism" and "an inability to communicate effectively," while barely mentioning care for the seriously mentally ill.

In 1983, the Mental Health Center for the seriously mentally ill, for its part, was looking for a way to deal with the stigma associated with its primary clients.

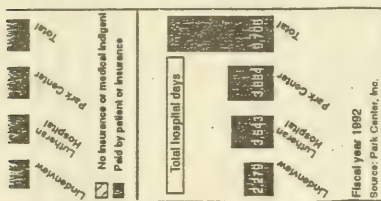
McKee said at the time that the name change "would enable Park Center to better reach those persons who need counseling services for life adjustment problems and problems with family and personal problems."

It worked. According to statistics released by Park Center, about 1,129, or 13 percent, of the 8,538 clients served in fiscal year 1992 were considered seriously or chronically mentally ill — the same population to which the center receives \$1.35 million of its \$11 million annual budget.

The \$3.35 million figure doesn't take into account about \$1.1 million from Allen, Adams and Wells counties that can be used for any purposes.

McKee and Lundy defended the center's counseling programs, saying those programs help stabilize clients and save the state up to \$5.25 million annually — \$2 million more than the facility receives in direct financing.

Park Center, however, has requested to meet the legal requirements for receiving state money.



Fiscal year 1992
Source: Park Center, Inc.

...in his criticisms of the Fort Wayne institution. Almost every mental health professional with whom The Journal Gazette spoke said that Park Center doesn't provide enough services to its seriously mentally ill.

Park Center's defense: "The center has 'no legal obligation' to provide more services than it does now, Lundy said.

Changing role

Park Center's role in the community has changed dramatically since



...The victims extend to Allen County taxpayers, who help foot the bill.

Allen County Council members Sandra Itonian and Nelson Peters recently questioned why county taxpayers must foot 9 percent of the cost of the center, which receives state and federal money.

"There doesn't appear to be any kind of accountability," Peters said about the \$1.1 million of uncommitted county taxes from Allen, Adams and Wells.

"Where is the money going? he asked.

An evolving story

Indiana's comprehensive mental health centers are among the worst in the nation, according to Dr. E. Fuller Torrey, national director of care and services for the seriously mentally ill.

In a biennial rating of the states published in 1990, Torrey ranks Indiana "no higher than 40th, and dropping." It is headed for the bottom.

To understand Park Center, you first have to understand a system called Comprehensive Community Mental Health Centers.

Initiated in Indiana in the early 1970s, the system pays regional facilities to provide care for the seriously mentally ill. Those who can pay are supposed to get the services they always want.

A survey by the advocate group the National Alliance for the Men-

wrong thing," he said. Later, they (inspectors) would go out and make sure the hallways were safe and the hot water was working.

Dorland will produce a program in the Indiana General Assembly this session that would create a system called the Hoosier Assurance Program.

Under the program, mental health money would be assigned to individuals, instead of programs. If the individual doesn't receive a service at the counseling center, the facility doesn't get paid.

No matter what happens in the legislature, Park Center is likely to remain a lightning rod for criticism. "People feel there is a social obligation" to provide care for all who need it, said Kurt Carlson, executive director of the Hoosier Center. "But there is no federal money. So the care is a reality — there isn't enough funding for all the needs."

"Well-meaning people say they (the mentally ill) have to have service — it's your (Park Center's) job. It looks like the center isn't doing its job, when it's doing all it can," says Carlson.

When the charge enough of the system aren't falling squarely on the shoulders of the poor, Larson said.

"No one at Park Center is going hungry tonight because they didn't get their paycheck," Larson said. And we still have homeless wandering the streets because of people committing suicide. We need to have people in our jails who haven't committed crimes. We will have people dying."

enough public attention on the domestic agenda to force congressional cooperation. An early blunder could shrink his stature at home and abroad.

Major, unfinanced business that will demand Clinton's attention includes:

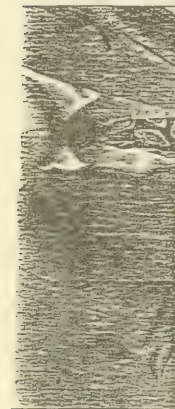
Secretary General Boutros Boutros-Ghali, who wants Somalia to be said for his peacekeeping force.

■ The Holocaust: The Bush administration's late push for a U.S. Security Council resolution to force Israel to accept a two-state solution has been a public relations disaster.

To some extent, Clinton will be compelled to compensate for his recent high-profile actions. For instance, Clinton's public opposition to the delivery of humanitarian aid to

Chad.

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CATHIE POWELL FOR THE JOURNAL-GAZETTE

Park Center board chairman David Lundy

the Indiana Center for Mental Health, Lundy said, "Where does the money go?"

Park Center is reviewed annually by Ernst & Young, certified public accountants. The Indiana State Board of Accounts reviews the external reports of the Hoosier Center. But the state doesn't have a policy with non-profit agencies that receive tax money.

In an Aug. 10 memo to Park Center's board of directors, Ernst & Young stated it selected certain transactions to review, but its "procedures were substantially less in scope than an audit."

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One of the cure government financing guidelines for community health centers is that they provide 24-hour emergency care. Park Center has a walk-in clinic open from 9 a.m. to 5 p.m.

The center does operate a phone line for help but if callers need to be admitted, they are referred to Lullitron or Parkview Memorial hospitals.

Chace Krichum, assistant deputy director for contract services for the State Division of Mental Health, said the guidelines for 24-hour care are "unrealistic for 24-hour care."

He said Park Center might not be able to provide 24-hour care, but it could provide 24-hour care for the most serious cases.

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CATHIE POWELL FOR THE JOURNAL-GAZETTE

Dr. James McKee, Park Center president and CEO

He founded a mental health clinic in the Kearney Grand Island, Neb., area, and worked at another clinic in Independence, Mo., before joining Park Center about 10 years ago.

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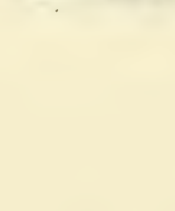
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CATHIE POWELL FOR THE JOURNAL-GAZETTE

Salary

From Page 1A

without the facts."

He said the Park Center board annually reviews McKee's salary and that for comparable executives of the Mental Health Center.

He said Park Center might not be able to provide 24-hour care, but it could provide 24-hour care for the most serious cases.

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FW News Sentinel 2-8-93 By The News-Sentinel

Park Center patient sets herself on fire

► The Wells County woman is in critical condition.

By JOHN HOOGESTEGGER
of The News-Sentinel

A Wells County woman who was a patient at Park Center suffered severe burns yesterday afternoon when she set herself on fire, authorities said.

Deanea Surbaugh, 26, of Bluffton was taken to the St. Joseph Medical Center burn unit about 1:30 p.m. yesterday in critical condition. The hospital declined to provide an updated condition this morning.

Authorities said Surbaugh told

paramedics on the way to the hospital that she set herself on fire using her lighter and a can of hair spray. She told the paramedics she did it after she heard voices telling her to set herself on fire.

She was admitted to Park Center on Jan. 29. Police said Park Center employees told them Surbaugh had been particularly despondent yesterday because it was her marriage anniversary and she is now divorced.

Fort Wayne firefighters were called to Park Center at 909 E. State Blvd. at 1:25 p.m. to battle the blaze in Building 7. There was very little property damage.

Fort Wayne police were called in to investigate the incident as an attempted suicide.

FW News Sentinel 2-10-93

Bluffton woman who set self on fire dies

By JOHN HOOGESTEGGER
of The News-Sentinel

A Bluffton woman who set herself on fire Sunday at Park Center died last night from her burns.

Deanea Surbaugh, 26, died at 6:23 p.m. yesterday at St. Joseph Medical Center. She was suffering

burns over 80 percent of her body.

Surbaugh was taken to St. Joseph about 1:30 p.m. Sunday after setting herself on fire. She told paramedics en route to the hospital that she had started the fire with a lighter and a can of hair spray.

Paramedics also told police that Surbaugh said she set herself on fire because voices told her to do it.

The police said Park Center employees said Surbaugh, who entered the center Jan. 29, was despondent Sunday because it would have been her anniversary

had she not been divorced.

The fire was contained to Surbaugh's room at Park Center and did not cause major property damage. It is not known how she obtained the lighter, because center patients are not allowed to have lighters or matches.

County Council plans review of financing for Park Center

By BRIAN HOWEY
Staff Writer

Allen County Council members who have been pressing Park Center on how it has been spending its property tax levy have had the right to review the agency's annual budgets for more than two decades.

Provisions in the Indiana Code allow the Allen, Adams and Wells county councils the statutory right to review Park Center's annual budgets — an action none of the councils has performed since Park Center Inc. was designated a community mental health center in 1976. Since that designation, Park Center has received \$89.5 million in federal, state and county funding, including \$12.5 million from the three counties.

This revelation comes as officials from Park Center Inc., the state-designated community mental

health center for the three counties, prepare to appear before the Allen County Council at 8:15 a.m. Thursday as that fiscal body attempts to secure some elusive answers to what tax money has been spent for.

Rep. Bill Long, D-4th, has written the inspector general of the U.S. Department of Health and Human Services seeking to review a study of Park Center already completed. David Early, press secretary to Long, said the congresswoman does not know what the HHS study found.

A 0.4 percent tax levy generates \$115 million from Allen, Adams and Wells county taxpayers, yet Park Center has budgeted \$419,871 in additional charges to Allen County taxpayers through services to the Department of Public Welfare for fiscal year 1993. In 1992, Park Center charged the county an

additional \$313,256, up from \$103,851 in 1991, \$42,995 in 1990, and \$13,491 in 1989.

"We are going to ask the question, 'We're giving you \$1.1 million, why are you still charging us?'" said Councilman Dan Heath, who will also request oversight of Park Center's annual budget.

Added Councilman Nelson Peters, "I will reiterate my request from the last time that nobody addressed, which is where are county dollars going?" That was in reference to the Jan. 25 special council meeting when Dr. James McKee, Park Center's chief executive officer, appeared before the council to answer questions.

"I was told that \$1.1 million gets thrown in the hopper and gets dispersed," Peters said. "That's not good enough. I would like to take a

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hard look at their budget as to how those dollars are going. We've requested that and haven't gotten anything. There are a lot of questions. I'd like to know why we're not getting answers.

Indiana Code states, "After the auditor of each participating county has certified that the county has met the provisions . . . the Division of Mental Health shall examine, approve or modify the submitted budget for each center after review of the participating county bodies." Heath said Friday that he will demand a line-by-line review of Park Center's budget, as well as previous budgets "so that we can make comparisons." The review process has been in the Indiana Code since 1971.

"We will be asking for a detailed budget," Heath said. "We have a statutory duty to review their budget."

Should the county expect to get \$1.1 million in services out of the \$1.1 million in unencumbered tax money? "Absolutely," Peters said. Peters has requested the Indiana State Board of Accounts to audit Park Center, which has been audited annually by an accounting firm it hired, Ernest & Young.

Peters said Michael Bozynski, supervisor of not-for-profit organizations at the Indiana State Board of Accounts, responded, saying such an audit would be a "duplication of efforts undertaken by Ernest & Young."

Bozynski further stated that his office "does not currently possess the resources to perform such an audit," Peters said.

"We need help," Peters said. "We have a bunch of unanswered

questions." Asked how he was prepared to respond to the council on Thursday, McKee explained, "I don't know. We did respond before. What we're basically going to do is show what services we provide, and how many people we serve, and how we use the money from all our sources."

"I think one other thing we'll show is if we didn't collect money from pay sources, we'd experience a significant decrease in the number of people we serve," McKee said. "Department of Public Welfare only pays 50 percent of the total fee already. We mentioned that at the last county council meeting."

Where does the \$1.1 million go? "We have a lot of 'last dollar' money," McKee said. He explained the phrase "last dollar" by saying, "We don't get full payment from anybody for our services. In order to do what we do, we have to fill in our services. If somebody pays 50 percent, we have to figure out how to come up with 50 percent. We're talking about anybody since we don't discriminate on ability to pay. We have to figure out how to make up the difference."

"I'm sure I didn't explain it very well," McKee said of the Jan. 25 meeting. "It's a difficult concept."

Heath said the unencumbered county tax money should be specifically designated to support services for only those people eligible.

"I would hope they're taking state and federal money and keeping that separate from private fees," Heath said.

"If a person comes in who qualifies for state money, they should draw that money. If a private person needing service doesn't qualify, they should not get those fees."

Those funds should not be commingled. That accounting function should be rather easy to follow."

Allen County Council members are frustrated by an explosion of welfare costs along with the lack of explanation as to where levied tax money is spent.

The council is faced with floating a \$4 million bond issue to cover alternate family and children services in 1993.

They have been warned by welfare officials to expect similar demands for bond issues in the years to come.

It's becoming a problem for counties throughout Indiana. The Association of Indiana Counties revealed that in 1992, of the \$30.4 million in excess levy appeals, \$19.2 million — or 64 percent — went to cover welfare costs. Fifteen counties were ordered to borrow another \$15.3 million to fund the system.

These increases accounted for a \$35.7 million increase above the maximum levy for one year alone. In seven counties, the welfare fund is larger than the county general fund, the AIC said. In 10 years, the state welfare program has increased by 179 percent.

Park Center accounted for only a fraction of the \$4 million Allen County will have to bond, Pam Porter, the county's child protection chief, said. An exact figure from DPW was not available late last week. But of all the agencies taking Department of Public Welfare cases, only Park Center receives a tax levy.

Heath met with a number of area legislators last week to discuss his frustrations over Allen County getting stuck with its \$4 million bond.

If the county doesn't float the bond issue, the state will mandate

that they float the bond issue. "There is less incentive for the state to promote efficiencies when counties pay the bill," Heath said. "The General Assembly and the governor should look for non-property tax funding sources."

Heath said he will explore having the state designate more than one agency as a community mental health center.

"It appears to me you can have more than one designation per county," Heath said.

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From News-Sentinel 3-17-73

Council scrutinizes costs charged by Park Center for helping kids

By DEBRA KRAJNAK
of The News-Sentinel

Why does Park Center charge local welfare officials for helping abused, neglected youngsters, when the center already receives property tax revenue to care for Allen County residents?

And exactly how are those property taxes — which will total about \$971,000 from Allen County in 1983 — spent by the community mental-health center?

The Allen County Council will continue that debate tomorrow at its regular monthly meeting at 8:15 a.m. in the County Commissioners' courtroom on the second floor of the City-County Building.

Dr. James McKee, Park Center's chief executive officer, tried to answer those questions at the Jan. 25 meeting. He will provide more information tomorrow.

McKee has said that because agencies such as the Division of Family and Children (formerly the Department of Public Welfare) don't pay the full cost of services, the balance must be covered by property taxes. The additional income also allows the center to help more people, he said.

Council members also are concerned about the quality of 24-hour emergency mental-health care the center is providing, services required by state law.

The center, which receives two-thirds of its \$11 million budget from government sources, expects to have received \$1.1 million from Allen, Wells and Adams counties in property taxes by June 30, the end of this fiscal year.

"We think we should be able to track where the \$1.1 million goes," said Dan Heath, the county councilman in charge of looking at the center's operations.

The state requires that 4 cents of every \$100 of assessed property valuation be paid to Park Center as

On the County Council's agenda

The Allen County Council, at its meeting tomorrow, is expected to address the following issues.

CIVILIAN JAIL WARDEN: The council will consider allowing Sheriff Joseph Squadrito to hire a civilian warden to run the Allen County Jail. Historically, the jail has been overseen by a deputy chief at a yearly salary of about \$34,000 plus benefits that can boost the actual yearly earnings to more than \$40,000, Squadrito said. A civilian warden would earn about \$30,000, and there wouldn't be an outlay for uniforms, liability insurance and other extra costs.

"I need an administrator in that position, not a police officer," Squadrito said.

Currently, a captain is temporarily running the jail. He will return to the Civil Division if a warden is hired.

The sheriff also needs \$23,000 to cover the costs of transferring 22 inmates from the jail to jails in other counties to relieve overcrowding. They will stay in those counties for about two months to finish their sentences.

YOUNG SEX OFFENDER PROGRAM: The council will consider hiring a probation officer to oversee a program for young sex offenders, some as young as 7, said Ken Watson, chief juvenile probation officer. There are 14 boys undergoing counseling who are supervised by Watson's Allen Superior Court staff. Since the program started in August, probation officers have been pulled from other duties to help, he said. Watson seeks \$28,000 to hire someone.

The number of sex offenders under 18 has grown from 20 in 1983 to more than 71 last year. Watson argues that if the youngsters were institutionalized, it would cost \$175 per day per offender. Using his own staff, the cost is \$27 a day, he said.

LAND FOR NEW JUVENILE DETENTION CENTER: The council will consider a request by County Commissioners who want to spend up to \$500,000 to acquire five acres to expand the site of a future juvenile detention center at 3651 N. Clinton St. They already own five acres where the I.J. Recycling plant once operated. The hazardous-waste processing plant closed in 1986 after a fire and chemical reaction forced an evacuation.

WOOD YOUTH CENTER RENOVATIONS: The council will consider a request for \$35,100 to finish renovations at Wood Youth Center, where young offenders have done extensive damage to walls, floors and fixtures, Watson said. The project will have cost about \$170,000 once it is completed in about two weeks, he said.

the designated mental-health facility for the three counties.

The Division of Family and Children, which provides welfare assistance and foster-care programs for abused children who become its

wards, plans to borrow up to \$4 million to cover a 1983 budget shortfall. Officials blame part of the increased expenses on hefty rates charged for institutional care for troubled youngsters.

BRIEFS

SOCIAL SERVICES

Park Center not treating its fair share, Council told

► Despite a shortage of beds, the facility cooperates with other groups to meet mental health needs.

By DEBRA KRAJNAK
of The News-Sentinel

Park Center's shortage of beds for the acutely mentally ill means mental health centers such as Lindenview are shouldering a greater burden of psychiatric care, usually free of charge.

That was the message Lindenview Executive Director Jerri Lerch brought to the Allen County Council yesterday as members sought opinions from mental health professionals about Park Center's role in the community.

They all agreed that the center at 909 E. State Blvd. doesn't have enough beds, but they said the center has made more of an effort in recent years to coordinate with other mental health facilities to meet community needs.

Since January, the council has been trying to determine how Park Center spends \$1.1 million in property tax revenues from Allen, Wells and Adams counties and why it also charges the local public welfare agency for services. Through June, revenue from the Division of Family and Children is expected to reach nearly \$420,000.

The council believes the center shouldn't bill the division while still receiving tax revenue, especially because the local Division of Family and Children must borrow up to \$4 million this year to cover a budgetary shortfall, partly because of hefty fees charged by institutions to counsel and house abused and neglected children.

In addition, the council is concerned about allegations that Park

Center not only doesn't have enough beds for the three-county area it serves but doesn't offer adequate 24-hour emergency care and has turned away indigent people needing help.

The center is designated as a Comprehensive Community Mental Health Center by the state, which means it receives tax dollars to serve indigent people. But, with only 12 acute-care beds, it's not pulling its weight, Lerch said.

Lindenwood is accepting up to seven patients a day that Park Center should be treating at no cost, she said. Also, the number of people who are unable to pay for services has been steadily growing.

"We handle a lot of the overflow," Lerch said.

That is partly because Park Center is open only as a walk-in clinic from 8 a.m. to 5 p.m., she said. Counselors staff phones until 1 a.m.; after that, an answering service contacts an employee on call. Callers who need immediate aid usually are referred to other mental health centers during the night.

Park Center doesn't reimburse Lindenwood for its services, either, Lerch said. She has suggested that the center contract with local hospitals and centers that provide services to people it should be helping, but efforts to do that haven't been successful.

"I think we're doing an effective job with what we have," said Dr. James McKee, Park Center's chief executive officer. "But, I would like to do more."

"We're not doing (just) minimum compliance," McKee said.

He said the center's 24-hour emergency services and number of beds meet state standards and that no one is turned away.

The center wants to put together an emergency services team that would be on call all night to go to

people's homes and add beds. So far, it hasn't had enough state funding to do so, he said.

Also speaking to council were Jane Novak from the Alliance for the Mentally Ill, who said Fort Wayne needs a 24-hour, walk-in crisis intervention center so people don't end up in emergency rooms seeking help. Many people don't realize they can call the center, or if they do call, they're too shy to demand help, she said. Novak is also on the advisory board for the state Division of Mental Health.

Her son, Chip, once a champion local golfer, suffers from schizophrenia and manic-depression and was once treated at the center. Novak said many people who seek free help at the center do so because their insurance won't cover their conditions.

Responding to financial issues, McKee said it's impossible to track how the \$1.1 million is spent because it goes into the center's general fund.

He encouraged the council to designate a liaison to the center who would be involved in the center's annual budget-making process, and he promised to report back to council on a regular basis.

"I think if we can be part of the budget process, it will allay any fears of misspending tax dollars," said Council member Dan Heath, who has been leading the Park Center investigation. Council members want the center to keep tax money in separate funds.

Heath said the center is required by state law to let the council review its budget, but that has never been done.

On an unrelated topic, Sandy Frantz, who was once a ward of the Division of Family and Children and lived in one of Park Center's group homes, asked that the center investigate its practices of giving out medication. Frantz alleged that she was overmedicated while under the center's care.

EDITORIALS

Sunday, March 28, 1993

The Journal-Gazette

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Park Center spat

State bill to smooth community debate

A bill making its way through the Indiana legislature could clear up issues that spawn local mental health funding disputes, such as the ones we've in recent weeks between Park Center and the Allen County Council. Everybody would welcome that. But there is concern in some corners that the new funding formula proposed by the Bayh administration will result in less access to care for the mentally ill and a decline in care. The concerns merit full consideration by area legislators and those throughout the state.

Most fundamental to the local debate is how a county can account for the support it gives a community health center. Allen County government contributed \$1 million to Park Center's budget this year, but that contribution is mixed with all other federal, state and fee revenue the center receives. That has frustrated council members.

The Bayh administration's new proposal, which is part of House Bill 1702, would establish income guidelines and track the level of service offered to all clients. This will give local communities a more accurate profile of whom is being served. But Jody Hoffman, a health policy analyst for AFSME, the American Federation of State and Municipal Employees, says the bill speaks plenty about making services more cost effective but little about improving quality of care.

Under the Bayh plan, Hoffman said, the state will "cement" what is now a casual mental health care monopoly system in regions across the state. Contracts to places like Park Center will be exclusive and there is little discussion about tying a contract to quality of care.

The state contends it has

two quality-control mechanisms in the bill. There is a requirement that centers move from a "continuity" of care model to a "continuum" of care model. According to Dr. James McKee, executive director of Park Center, that means patients will receive long-term services tailored to their needs, as opposed to being slotted into an already established program.

A second state initiative is the creation of a board, whose majority will be mental health advocates, that will regularly review the quality of care and a center's profile of clients to make sure the most needy are being served and served adequately.

Carol VanDusen, office manager for the Indiana Alliance for the Mentally Ill, is enthusiastic about the bill. She said the deficit-funding model — whereby counties fund the annual shortfall up to a limit — "hasn't worked. The money could be used for anybody that comes through the door," she argued.

VanDusen also believes that the new board will make a difference. But Hoffman said the board can only be as effective as the state allows it to be, and it's not likely that the state will allow the board to have significant control over mental health services. Not in the bill, but a part of the Bayh administration's policy is a concentrated effort to relocate more patients from state hospitals to programs offered by community centers. That could affect access to treatment by the mentally ill. We have said before that the overriding emphasis of the Bayh administration and the 1993 General Assembly seems to be on cutting costs, but if Indiana's public officials don't start balancing costs with the quality of care, the savings will be in vain.

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4-13-93

FT W Journal Gazette

County may withhold Park Center payment

By BRIAN HOWEY

Staff Writer

Several Allen County Council members are talking about withholding a payment to Park Center for the second time this year when the council meets Thursday morning.

On March 18, the council voted unanimously to withhold a \$46,842 payment to Park Center Inc., the state-designated community mental health center. That funding comes from a property tax levy in Allen, Wells and Adams counties that generates \$1.115 million a year. The \$46,842 is a one-time allocation based on final assessed valuation figures making up the difference between actual taxes collected and the assessments.

"That's on the agenda," said Councilman Dan Heath of the allocation that will greet the council when it meets at 8:15 a.m. Thursday in Room 200 of the City-County Building. "It's my understanding that if

they (Park Center) wanted to, they could go to court and mandate that."

The council withheld the payment in March after members complained they didn't have information as to how the tax revenue is being spent. Heath said the council will eventually approve the fund transfer.

"We probably can't hold that up for too long, but we certainly can make a point, and that's what has been happening," he said.

McKee didn't appear to be worried about receiving the payment. "I didn't even know about it," he said Monday. "We'll need to follow up on it. I don't have any information."

Councilman Nelson Peters said Saturday that he is exploring a move that would allow the council to distribute the community mental health funding to more than one agency. Heath said the council could

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pass a resolution calling for the change, but it would ultimately be up to the Indiana Department of Mental Health to sign any contracts.

Council members have expressed concern that Park Center doesn't provide 24-hour walk-in emergency care, nor does it have enough beds to care for acutely ill patients. Many patients for whom Park Center is designated to provide care are sent to Parkview Memorial Hospital's Lindenview Regional Behavior Center and Lutheran Hospital. In March, Lindenview Director Jerri Lerch said they absorbed 125 Park Center patients in 1991 and 260 cases in 1992.

"We could certainly pass a reso-

lution expressing our desire for that," Heath said of multiple designations. "Our ability to force that issue is pretty limited."

Such a move may be contingent on whether House Bill 1702 passes the current session of the Indiana General Assembly. It's original form would allow the designation of more than one community mental health provider. However, it was watered down in the Senate, and it will be up to legislative conferees to determine whether multiple designations will be allowed.

In another item tabled from the March council meeting, the Allen County commissioners will again ask for a \$500,000 appropriation to purchase two properties next to the I.J. Recycling plant that will be demolished to build a new juvenile detention facility.

Helmke to discuss jobs

summer job programs and make them work.

"The issue is, are kids being paid to be paid, or are they doing work

center. It is expected to cost about \$15 million, plus an additional \$5 million in "soft" costs. Those plans call for a 112-bed facility with the potential for expanding to 176 beds.

The architect fees would be 7 1/2 percent, although, McComb said, "We still have to talk to the architect yet." Moake Park Associates Inc. of Fort Wayne is the architect.

Peters and Councilwoman Sandra Houlahan raised doubts about the plans on March 17.

Arson suspect gets new lawyer

counts of aggravated murder and one count of aggravated arson.

Originally scheduled for May, the trial is tentatively set to begin July 21. A June 7 pretrial date was also scheduled Monday.

Mohr is accused of setting a January 1992 fire that killed three people. If convicted, he could receive the death penalty. He has pleaded

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GOVERNMENT: More on 7A

Welfare shortfall to get hearing

► Allen County Council is expected to turn down a request for \$3.8 million.

By DEBRA KRAJNAX
of The News-Sentinel

Issues spurred by the unending community battles against crime and poverty will dominate the agenda for the Allen County Council tomorrow.

The largest item the council will consider is a request from the local office of the state's Division of Family and Children for \$3.8 million to cover a budget shortfall for foster and institutional care, adoption aid for hard-to-place children and family services.

The council is expected to turn down the request, thereby freeing the agency to borrow the money.

Here are other key items up for discussion or a vote:

◆ Wayne Township seeks from the council \$2.1 million to cover poor-relief claims and at least \$418,000 for reimbursement of payments to local hospitals that provided maternity care to poor women between 1980 and 1986. The township paid the bills.

The council is expected to turn the requests down, forcing Wayne Township to borrow the funds.

◆ Allen County Commissioners and architects will review options for building a new juvenile jail to replace Wood Youth Center. The county wants to build the jail at the site of a former hazardous waste processing plant, L.J. Recy-

Council convenes

The Allen County Council meets at 8:15 a.m. tomorrow in the County Commissioners' Courtroom on the second floor of the City-County Building at Main and Calhoun streets.

property won't be bought.

◆ Sheriff Joseph Squadrito wants \$25,000 to continue housing some prisoners at jails in other counties because the Allen County Jail is overcrowded. He received \$23,000 in March for that purpose.

Squadrito also seeks \$318,000 to replace an outdated television monitoring system at the jail.

◆ County Commissioners are requesting \$46,873 for Park Center, the community's mental health center. The money is due the center from property taxes collected for mental health services.

Some members are upset because the center receives tax revenue yet still bills the local office of the state Division of Family and Children for services and because the center doesn't offer 24-hour walk-in services.

ding, at 3651 N. Clinton St. The new center could cost up to \$25 million.

Commissioners seek \$500,000 to buy five acres next to the L.J. site and to tear down buildings there. They already own the five acres where the vacant plant stands. If contamination under the old L.J. buildings precludes the use of the site for a juvenile center, the extra

4-14-93
FW News Sentinel

4-14-93 FT W News Sentinel

Advocate group helps patients fix problems

► Mental-health patients get support and information.

By RICHARD TURNER
of The News-Sentinel

When the relationship between patient and mental health-care provider breaks down, a new group in Fort Wayne can help remedy the situation.

The Mental Health Consumer Advocate Group, formed in February, is based on a similar group in Indianapolis called Knowledge Empowers You, or KEY, said Cathy Roenke, president of the local group.

Previously, people who have had complaints or problems had no place to find help, said Roenke, of the 3800 block of Newport Avenue.

"People who have had problems haven't had a place to get them solved; they've just had to forget about them," she said.

Roenke said the group serves

three functions: advocacy, support and information.

As an advocate, the group can provide help for people who have had problems with any provider of mental-health care. The group also is providing input into the reorganization of Park Center.

"In Indianapolis, the KEY group is very active, especially with people at the state hospitals," Roenke said.

The mentally ill also can find support and understanding from others in the group who may have similar illnesses.

Group members want to inform people seeking help of resources available to the mentally ill. They also hope to build public awareness.

"We want to get out a lot of information so that we can remove the stigmas on the mentally ill," Roenke said.

The group is planning a special meeting at 10 a.m. April 16 in Room 126 in the Novitsky Building at Park Center. Anyone interested or needing help can attend.

County shops for Park Center alternatives

By BRIAN HOWEY

Staff Writer

A resolution that would designate institutions other than Park Center as a community mental health center was unanimously passed by the Allen County Council on Thursday.

The resolution isn't binding, but reflected concerns of council members who said Park Center does not

offer 24-hour on-site emergency care, refers indigent patients to other centers and does not have enough beds for the acutely mentally ill.

The council also voted 5-1 Thursday to make a \$46,800 payment to Park Center, only because members knew the state could mandate the payment. Councilman Nelson Peters dissented, and Councilman Robert Armstrong said,

"We have all types of questions, including that if the payment isn't made, it will be mandated."

The resolution was the council's way of "sending a message" to Park Center and the Indiana Department of Mental Health, which awards contracts for community mental health centers.

"We've had a lot of questions," Peters said, noting two recent appearances by Park Center's Dr. James McKee. "I don't know if we got all of our questions answered. I would like to see us pass a resolution and send a message to the state."

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Park Center

From Page 1A.

state."

The action comes despite an offer made by McKee in March to allow the county council to take part in its budget process. McKee said earlier this week that process will begin in May. The council has had the statutory right to review Park Center's budget for years, although it hasn't done so.

Dr. Juana L. Clay, of A Better Way counseling and diagnostic agency at 916 S. Calhoun St., told the council she had tried to get Park Center to subcontract services to her agency.

"I've had three meetings with Dr. McKee canceled," Clay told the council. "We wanted to suggest Park Center allocate part of their state budget to the inner city."

Clay said Park Center had referred "a few" clients to A Better Way in the past. She said she had made a request to Park Center in June 1992 to set up subcontracted services for minorities.

"We're letting them get away

with all of the resources," Clay said of Park Center.

McKee was unavailable for comment. It is unclear which centers might be eligible to subcontract with Park Center or receive a designation from the state. Lindenvue Regional Behavior Center, Lutheran Hospital and Charter Beacon have been mentioned by council members as potential alternatives to Park Center. Another was the Bowen Center in Warsaw, already designated as a community mental health center for the Kosciusko County area.

No one was available from those institutions Thursday.

The council and Clay expressed hope that House Bill 1702 will pass in the Indiana General Assembly; it would pave the way for multiple community mental health center designations. That bill is before conferees after passing the House and Senate.

Park Center receives \$1.115 million a year from a property tax levy mandated by the state on taxpayers in Allen, Adams and Wells counties.

FILED IN 16-03
JAN 16 1993
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March 24, 1993

Congressman, Ron Wyden, Chairman
 Honorable Members of Committee on Small Business
 B-363 Rayburn House Office Building
 Washington, D.C. 20515-6318

Dear Congressman Wyden and Honorable Members of the Committee:

My name is Bud Breithaupt, I am the step father of a profoundly mentally retarded and physically handicapped 32 year old daughter, Margaret. Margaret has spent 17 years of her life living at Fairview Training Center, Salem, Oregon, where she is currently receiving some of the finest care that is now available to the Mentally Retarded Developmentally Disabled(MR/DD).

From December of 1989 to December of 1992 I served as president of the Fairview Parents Association, a not-for-profit volunteer group that was formed by the families and guardians of residents living at Fairview Training Center. The association now includes a sizable number of parents whose family members were relocated to the 5 person Waiver Program that has been touted "as good or better than Fairview". During this same period I also volunteered to serve on the state of Oregon's Developmental Disabilities Long-Range Planning Committee. This committee was convened for the purpose of determining "what to do with Fairview after 1992"; July of 1992 being the end of the Community Integration Program phase 2(CIP II). This would ostensibly finalize the state of Oregon's Plan of Reduction-Plan of Correction. At this time the targeted excess population of 1000 plus persons living at Fairview would have been main-streamed into the community at large.

The concept of expanded services in the community setting are absolutely essential as supplementary to the federally mandated, Title 19, Intermediate Care Facility Mentally Retarded(ICF/MR)Program. However, without the federal oversight, HCFA or the other adjudication agency, U.S. D.O.J. Civil Rights Division, the community programs are absolutely vulnerable to extreme criminal abuses.

No consistent, understandable policies or procedures for accounting

for public funds used in community programs; there are no independent performance audits. Expenditures loosely averaged resulting in various strategies for expropriation of funds by nefarious providers indulging in "skimming", falsification of records, theft of publicly financed properties, food stamp abuses, excessive service and program charges, racketeering scams, misuse of funds for non-related interests, in short, many, many, options to steal with impunity.

A number of the Mental Health Division's policies have not proven to be incentives to attract high quality service providers to pick up the slack created by a terribly overburdened and underqualified system. Which is not to say that there are not a number of good providers currently doing business in spite of the Division's announced intentions of reducing accountability of community programs in safety, health and human rights areas, exposing programs and residents to becoming vulnerable to changing and ill defined expectations.

I know only too well how cold and unforgiving the community can be to those souls that have been and are continuing to be placed with providers who aggressively operate totally inappropriate programs. These are for-profit as well as not-for-profit, domestic as well as out-of-state MR/DD corporations that are contracted directly by the Division to take care of our most severely compromised citizens at great expense and then do not deliver the product as contracted, but continue to pick up the check that in most programs is worth millions and millions of dollars.

In the last 7 years of my advocacy for the mentally handicapped I have seen their programs become hag-ridden with escalating abuses regardless of the mountains of state administrative rules and regulations categorically governing all facets of program performance requirements. The Division has at a minimum been neglectful and to the extreme, callous and totally unresponsive to the improprieties that are oftentimes revealed. I am concerned that the policies and directions of the Division, as it relates to the MR/DD population, are seriously flawed. My greatest concerns are with resident entitlements, fiscal accountability (no state requirement to implement impartial, outside, itemized performance audits). Lack of program stability, the contracting and oversight policies of the Division.

The 1000 people that have moved out of Fairview under the Plan of Reduction and the additional 55 residents that will be moved under Oregon's plan to reduce costs as the result of the states revenue losses are losing desperately needed entitlements. These include the guarantees of all needed medical and dental services. These services are not consistently available, the bulk of the community handicapped are on the straight medicaid-poverty-program and generally wait their turn for care in the emergency room approach or pro-bono relationships with the professional community.

When our people were/are living at Fairview or East Oregon Training Center(ICF)which are the last of the ICF programs, they have a funding base which is supported by a federally endorsed state plan. This relationship has proved a very resilient contract to insure the availability of essential accommodations and services in times of economic downturns and changes in political priorities. In spite of the well-known difficulties of meeting the federal standard's for excellence, the budget of the community Waiver programs are subject to review every two years, and to the arbitrary whimsies of the bureaucracy as we experience with mid-biennium adjustments. The community plan makes no provision to reduce or offset this increased vulnerability to reductions in the funding of sorely needed services(as indicated by the Measure 5 problem). Residents who have moved out of Fairview have lost the accountability and protection afforded by the high federal standards.

All of the small independent ICF's have been bullied into capitulation by the division. In fact as I write this testimony the last of the independent ICF was forced into submitting to the unregulated, fiscally unaccountable, non-mandated, unentitled residential Waiver Program or Supported Living Program option, the rationalization I received from the provider was that, if they did not comply with the wishes of the Division, their program would not be certified!

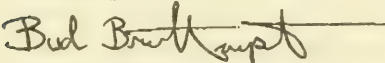
Our state lacks a back-up system which has the confidence and universal understandability within the small residential community. Because Fairview has been rendered inaccessible as a resource to the community even as short term respite care option in times of crisis for individual clients as it once was used and continues to be defined as such in the Oregon Revised Statutes, now the only

back-up strategies currently employed as options for MR/DD clients in crisis in the community is Damasch State Hospital for the mentally ill or the local jails!

Limiting checks and balances in the diagnosis and evaluation system, by reducing the role of the client team through the exertion of undue influence in the development and adoption of the Individual Support Plan(ISP)in the community programs. A number of providers - in particular the out of state, not-for-profit independants are not both-erred by the above compromise because they don't work the ISP's anyway- they just take the funding.

Most important is the loss of checks and balances that result with the move to the community. The community programs must be monitored by the public's agent for accountability and I don't mean bogus concepts like the Association for Retarded Citizen's Project AIM(Advocates in Monitoring). All of the ARC's data goes directly to the Division and what is done with it? No body knows! The concept is valid but early on it was co-opted by the Division and has no independence. The United States government must extend its scrutiny into the community programs and hold the states accountable. The present state of affairs in the small programs indicate a retrograde back to the "institution" stigma at its worst before the federal oversight was implemented and the community looks like the stereotypical congregate care facility in its early days splattered all over the state!

Sincerely Yours,



Bud Breithaupt
1511 NE 45th Ave #1
Portland, Oregon 97213 503-287-2004

March 25, 1993

Congressman Ron Wyden, Chairman
Honorable Members of the Subcommittee
B-363 Rayburn House Office Building
Washington, D.C. 20515-6318

Dear Congressman Wyden and Honorable Members:

My name is Vina Breithaupt, I am the mother of a 32year old daughter whose name is Margaret. Margaret has Rett's Syndrome; this is a devastating progressive neurological disorder affecting females. There is no known cause, cure or treatment. The syndrome is characterized by normalcy at birth followed by severe mental and physical disabilities. This disease is not only catastrophic to it's victims, but also imposes tremendous emotional and financial burdens on the families. The lack of knowledge and understanding of this devastating disorder hinder families in their ability to cope. To help our family of six cope (Margaret is the 3rd child of 4 children) we committed her to Fairview Training Center(FTC) 50 miles away in Salem, Oregon when she was 12½ years old. It was a very tough decision to make at the time but she adjusted easily; our family regained a sense of normalcy while Margaret made progress in areas she never could in the special classes in Portland.

When FTC was federally ordered to downsize I was told by the Mental Health Division that a community placement would provide care as "good or better" than what residents were receiving at FTC, I was dubious about that claim but told my social worker we might give a community group home a try. At this time we had heard of about as many sucess stories as we heard about dismal disasters or even deaths occurring shortly after leaving FTC. So,with some trepridation I agreed to a pre-placement visit with a provider who had enjoyed a fine history of residential care(ICF) over 35 years. There were needs assessment meetings and an exit meeting with the provider's staff at FTC where they also met my daughter. I was told because of some problems,Margaret would have only 10 days to see how

suitable the placement would ^{work} out for her instead of the 30 day time limit. If the program didn't seem right for her in the 10 days allotted, and we didn't bring her back to FTC immediately, then we had to forfeit that option altogether. On the other hand, a provider had 3 months, perhaps longer to make that decision. As it turned out the abbreviated stay was sufficient to clearly see this program would never work out for Margaret. The long-time provider's experience just didn't transfer into this program. Shortly after this happened the Division changed the rules of the Correction and Reduction Plan which then eliminated the trial period altogether for a resident! For more details of our experience please see attached letters, 1-4.

I joined the Fairview Parents Association in 1974, attended meetings, and later about 1980 became a board member. In 1986 I remarried and my husband and I became more interested in the issues surrounding the downsizing plan and in particular the unsettling effect it was having on residents and parents/guardians alike. Late in 1989 my husband "Bud" was elected president of the association and I was elected secretary. We held these positions until late 1992 when our 3 year limit was completed.

During our tenure as officers in the Fairview Parents Assn, we also became involved in other related activities like the Advocates in Monitoring(AIM). The AIM project came into being as a directive of the Plan of Reduction and Correction. It consisted of parents and consumers of MR/DD services to monitor services at the Community Integration Project I(CIP I) and also CIP II, first of those community group homes directly involved with the downsizing.

Bud and I monitored 2 homes the first time and 1 about 6 months later. We found all the homes were anticipating and arranging for our visits. The AIM project(which we assisted in developing) clearly states that visits were not to be announced! Interestingly, we visited the home our daughter had her pre-placement experience in and found none of the staff remained from our initial contact about a year previous. The attrition rate was so high in this home that the staff revealed

it was difficult to maintain a staff person there who would be able to give the clients physical therapy. The procedure they had established was to have a registered physical therapist from a service agency come out and teach one of the direct care staff the therapeutic exercises outlined in their plan of care. Now, on the face of it, that could probably work out, however when you are looking realistically at an attrition rate of 100 to 200% in the majority of the programs you will find this very important aspect of care for some extremely negligible. The staff stated that it was sometimes as long as 6 weeks before another staff was trained. For my daughter therapy needs to be conducted every day just to help her maintain her ambulatory skills.

In 1991 my husband and I along with other advocates pleaded before the state legislators to increase the pay of those who work in the group homes, as we felt this would go a long way to reduce the high attrition rate. We found out later though, that the raise was to go only to those in management positions, and sometimes it didn't go to them, but to the directors of the programs. Needless to say, we're really back where we started from, care workers leaving to take a less challenging position with a fast-food company. Until these folks can get the pay they deserve the problem will continue.

From October 1989 until June 1992 I served as a member of the Facility Human Rights Committee for FTC providing specific expertise in the area of developmental disabilities. Members of this committee met twice a month for 2 hours at a time. Occasionally, there would be an extra meeting. In March of 1992 we all had our contracts renewed with the state; my 3 year limit would have been up in October, however, many had served there longer, one had been there 4½ years, this was true also of the Area Committee members.

It will be interesting for you to note Con. Wyden, that the day after we met with you at Luther Memorial Church with our concerns regarding the business practices of a certain group home provider, I was sent the letter from the state (FTC) stating that my contract would not be renewed in July. (See attachment 5 and 6.)

During the last 4 years we have found ourselves personally advocating for parents or guardians who have had little or no response from the state in their efforts to receive some help for their family members with Developmental Disabilities, nor has any other advocating group come forward to assist them. On at least 4 occasions we took their plight to the press and the media, this apparently did some good. In addition we also supported the cause of a nurse employed at FTC who was fired after the death of a resident, later she won her case and her position was restored. We have news clippings and media clips from all of these for your perusal, if you would be interested please let us know.

We are not paid advocates, we just feel as our friends do, someone must step out and help those who can not help themselves and we seem to be them! What this state needs for these programs in the community is an Ombudsman program. Some providers encourage families to join together like an extended family which is good, others include resident rights groups which is really great but where can they go with their grievances if it isn't settled there? The problem may be simply one of quality of life, where do you go with that? Not likely Protective Services or even the director of Client Rights, (a small office with one director and two investigators for the whole state of Oregon) Then too, there are providers whom we've met who will go to great lengths to make certain visiting families don't show up at the same time, they say that would break the rules of confidentiality. This situation creates a problem far worse than the "institution" in its darkest days, true isolationism!

The nations MR/DD programs are desperate! We struggle to survive in the face of massive budgets; Oregon's Measure 5 is being used as a blanket excuse by those same legislators and state agencies that have historically evaded their professional responsibility to administer effectively those same programs that they sold to a trusting citizenry.

It is offered by the Mental Health Division that some 700 plus long-

residents now living in community programs who left FTC with great expectations - that life on the "outside" would be better and guaranteed on-going, will be sacrificed to Measure 5(1st round) and 100 plus residents from FTC are destined for the same raw deal, no supports and no programs.

This is the Pay-Off from the mental health professionals whose virtuous words provided the smoke-screen, hiding many self-serving agendas; the same people who asked for and got millions upon millions of dollars and have spent it with no budget and no oversight and are now complaining because they have to cut back!

Sincerely,

Vina S. Breithaupt
1511 NE 45th Ave # 1
Portland, Oregon (503) 287- 2004
97213

Date: Jan. 26, 1989

To: Marilyn Christoe, Social Worker, Patterson Cottage, F.T.C.

From: Vina Swenson-Breithaupt (Guardian for Margaret C. Hood)

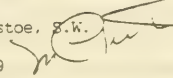
Subject: Termination of Preplacement Visit to Good Shepard Luthern Home's S.I.T.H.

The reason's presented here for cause of termination are for your information. This is only an outline and they are not necessarily listed in the order of importance.

1. Need more information regarding monitoring procedures of facility, residents and staff
2. Inexperienced or temporary workers
3. Poor communication with parent/guardian
4. Inappropriate delegation of authority
5. Insufficient staffing
6. Poorly defined duties for resident workers
7. No food on hand for residents on move-in day
8. Need more information on appropriate grouping of ability, sex, age of residents
9. More security/safe-guards in place at time of visit to insure clients protection
10. Pre-placement training needed by community staff on site at F.T.C.

The results of this pre-placement visit were very disappointing for us. We feel that many of our concerns would not be listed here if these placements were conducted at a more thoughtful, slower pace. Initially, what was created to enhance a residents status has now become a questionable situation; losing the progress they have made or even worse be subjected to situations that may be dangerous to their health or their life.

In conclusion, I believe there should be a moratorium on these community placements until such time a thoughtful re-examination of present methods resulting in solutions to common problems in community placements are resolved.

To: Representatives of the Fairview Parents' Association
 From: Marilyn M. Christoe, S.W. 
 Date: January 26, 1989
 Re: Community Placement

A transition for our clients to the community is a traumatic one for them. In order to lessen the impact, I recommend we look at the following concerns:

1. Placement into a home that is already set up and working, whether it is newly constructed or already established.
2. Ensure staff have been hired and satisfactorily trained.
3. Pertinent client records relevant to their daily needs, at the facility where the client will be residing, when they arrive.
4. Security measures previously determined to be of necessity, already in place and operating properly.
5. Budgets adequate with food staples purchased, stored and on hand.
6. A better way of establishing the clients are placed with compatible personalities.
7. A specific guideline for parents and significant others to know what is mandatorily expected of the group homes.
8. Perhaps an opportunity to work with parents of the other clients so they can, as a group, present ideas, etc.
9. Move clients in, one or two at a time, rather than all five of them on the same day.

I believe the majority of our clients at Fairview would benefit greatly from a smaller, less restrictive environment, but improvements are in order, before we are successfully placing our clients in such facilities.

March 6, 1990

Karl V. Reer, Development Team Specialist
 Mental Health Division
 Department of Human Resources
 2250 Strong Road SE
 Salem, Oregon 97310

Dear Karl:

My husband and I would like to thank you for your attendance at our daughter Margaret's I.P.P. Meeting held March 5, 1990 at Patterson cottage, Fairview Training Center.

We concur with your evaluation, that Margaret's Pica behavior and her one on one requirement of staffing would contraindicate her participation in a community program.

Margaret's Interdisciplinary Team echoed your concerns and added some of their own for consideration.

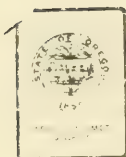
Consequently, with the unity of purpose and professional decisions made with integrity, I submit my request and consent that my daughter's name be removed from the community placement list.

Please send verification of this decision, so agreed to March 5, 1990, by letter.

Yours truly,

Vina E. Swenson-Breithaupt
 Vina E. Swenson-Breithaupt, Guardian for Margaret C. Hood, #8369
 1511 N.E. 45th Ave. #1
 Portland, Oregon 97213

cc: Mary Lee Fav, Mgr. Development Team, DD Program Office
 James Toews, Asst. Admin. M.H.D.
 Rosemary Hennessy, Supt. Fairview Training Center
 Fred A. Eldridge, Community Placement Coord.
 Interdisciplinary Team:
 Donna Burckardt, Psych. Aide I
 Anna Cech, Psych. Aide
 Sara Crawford, Unit Dir.
 Betty Hanson, Nutritionist
 Wes Hervey, Audio/Speech Pathologist
 Theresa Marsh, Rn.
 Lillian McGinness, Psych. Aide
 Patty Mohn, Q.M.R.P.
 Sally Smith, Shift Charge
 Debbie Solomon, O.T.
 Devin Spruce, P.T.
 Brenda Teague, Psych. Asst.
 Ethelyn Viltz, Recreation Program
 Doug Vincent, Program Coord.



Department of Human Resources

MENTAL HEALTH AND DEVELOPMENTAL DISABILITY SERVICES DIVISION

2575 BITTERN STREET NE, SALEM, OREGON 97310-0520

VOICE:

March 26, 1990

TDD - NONVOICE: (503) 373-1449

Vina E. Swenson-Breithaupt
1511 N.E. 45th Avenue, Apt. #1
Portland, OR 97213

Dear Vina,

I'm writing as a follow-up to our discussion with the Interdisciplinary Team on Patterson Cottage, on March 5, 1990, regarding community placement planning for your daughter, Margaret Hood. Coming into that meeting, we were projecting the development of a plan for Margaret, based upon recommendations of the Interdisciplinary Team, that could have led to Margaret beginning community placement in May of 1991. At the meeting, you expressed a preference that community placement planning for Margaret be deferred at this time. This position was unanimously endorsed by the Interdisciplinary Team. As I indicated at the meeting, I subsequently asked Eva Kutas, the Individual Advocate at Fairview Training Center, to ascertain if Margaret had any wishes or preferences in the matter. I am enclosing a copy of Eva's memo to me, indicating that she was unable to determine any desires or wishes from Margaret regarding community placement.

Referral for community placement planning for adults living at Fairview Training Center is based upon recommendations of the Interdisciplinary Team on the cottage where the individual resides; or in response to the expressed wishes of the individual, or the individual's guardian, or family, acting on his/her behalf. At this point, since neither Margaret, nor her guardian, nor the Interdisciplinary Team is requesting that she be placed, we are deferring placement planning for her--and will remove her name from the current placement list. At any point in the future, when either Margaret, the Interdisciplinary Team, or yourself (as Margaret's guardian) requests that placement planning be initiated, we can meet again to assess her needs and review available options. I would be pleased to meet and work with you then to help design an appropriate placement plan for Margaret, or to meet with you at any other time to talk about placement options in the community.

Yours truly,

Karl V. Reer
Development Team Specialist

Attachment

cc: Mary Lee Fay
Fred Eldredge
Sara Crawford, Unit Director, Patterson Cottage

AN EQUAL OPPORTUNITY EMPLOYER

DO NOT PUT YOUR
INFORMATION

STATE OF OREGON
PERSONAL/PROFESSIONAL SERVICES CONTRACT
(CONDITIONAL/NON-PERS MEMBER/CONTRACTOR)

1706

This contract is between the State of Oregon, acting by and through its Fairview Training Center
(Departments, Division, Board), hereafter called Department, and Vina Breithaupt
hereafter called Contractor. Department supervising representative for this contract is John Peterson

Effective Date and Duration

This contract shall become effective on 3/23/92 (or on the date at which every party has signed this contract, and when required, the Executive department and the Department of Justice have approved this contract, or whichever date is later). This contract shall expire, unless otherwise terminated or extended, on 6/30/93

Statement of Work

- (a) The statement of work is contained in Exhibit A attached hereto and by this reference made a part hereof
(b) The delivery schedule for the work is identified in Exhibit A.

Consideration

- (a) Department agrees to pay Contractor not to exceed the sum of \$ 870.00 for accomplishment of the work, including any allowable expenses.
(b) Interim payments shall be made to Contractor according to the schedule identified in Exhibit A.

Travel and Other Expenses

- (a) Reimbursement of travel expenses are allowed only as identified in Exhibit A.
(b) Reimbursement of other expenses are allowed only as identified in Exhibit A.

Amendments

The terms of this contract shall not be waived, altered, modified, supplemented or amended, in any manner whatsoever, except by written instrument signed by the parties.

Terms and conditions listed on back side

=====

CONTRACTOR DATA/CERTIFICATION AND SIGNATURE

Name (please print): <u>Vina Breithaupt</u>	Address: <u>1511 NE 45th #1, Portland, OR 97213</u>
Social Security #: <u>541-36-4627</u>	
Federal Tax ID#:	State Tax ID#:
Department Conditional Contractor Code: <u>XET0010AD</u>	

I, the undersigned, agree to perform work outlined in this contract in accordance to the terms and conditions (listed on the front and back side and made part of this contract by reference), and the statement of work made part of this contract by reference; and hereby certify under penalty of perjury that I am not in violation of any Oregon tax laws.

Approved by Contractor: Vina Breithaupt Signature/Title Secretary Date 7/16/92

=====

DEPARTMENT & OTHER SIGNATURES

Through Personal Services Position Numbers: _____

Within S & S Budget: _____

Budet Verified: _____

Personnel Services Requirements: _____

Approved by the Department: _____

Approved by the Attorney General's Office:
(all contracts & amendments to contracts over \$25,000)
Approved by the Executive Department: _____

Contractor signature: _____

Revised Date 1991

Agency Contract Number: 1492

[9] Yes [] No

John Peterson Fiscal Services/Business Services

3/16/92 Date

Shirley C. Hennessey Personnel Officer

3/26/92 Date

Shirley C. Hennessey Agency Representative/Superintendent

3/26/92 Date

Shirley C. Hennessey Assistant Attorney General

3-30-92 Date

Shirley C. Hennessey Program Manager

3/26/92 Date

Shirley C. Hennessey Name/Agency/Fairview Contract Officer

3/26/92 Date

attach 5

Oregon

June 29, 1992

*Rec'd
July 3, 1992*

 DEPARTMENT OF
 HUMAN
 RESOURCES

Vina Breithaupt
 1511 N.E. 45th #1
 Portland, Oregon 97213

Mental Health and
 Developmental Disability
 Services Division
 Fairview Training Center

Dear Vina:

I have been appraising the work of Fairview Human Rights Committee and trying to plan how we will address challenges at Fairview in the next several years. I am also appraising capabilities and interests of current membership.

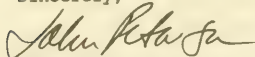
I will be suggesting later this week to Rosemary Hennessy that the mission of the F.H.R.C. be essentially realigned to be a strong resource for review of Fairview's programs, services, and client rights/protections/concerns. The F.H.R.C. will continue to focus on institutional concerns, and not on broader DD service delivery issues of great import, but less relevant to people who live at Fairview. We will try to not become involved with the endless array of issues based on community services and programs.

Membership on the committee will be changed to coincide with the "fiscal year" beginning July 1, 1992. I will recommend that your appointment to the F.H.R.C. not be renewed, as I perceive your strongest interests to be far broader than the F.H.R.C. agenda.

I am grateful for the service you have contributed to the Facility Human Rights Committee in the two years I have been here. You have become well known for the strong concerns and commitments you have to building community programs and services for disabled people.

I am willing to talk with you in person about this, and will have discussed it with Rosemary by the time we meet.

Sincerely,



John Peterson
 Individual Advocate

JP:va



2250 Strong Road SE
 Salem, OR 97310-0540
 (503) 378-5100

5'h attached

The Coalition Of Institutional Associations For The Mentally Retarded Of Maryland

An advocacy group of many parents, relatives, and friends of those unable to speak for themselves

April 6, 1993

The Honorable Hon Wyden, Chairman
Subcommittee on Regulation, Business Opportunities and Technology
363 Rayburn House Office Building
Washington, D. C. 20515-6318

Dear Congressman Wyden:

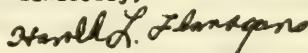
I appreciated the opportunity of attending the public hearing of your Subcommittee on March 29 concerning Residential Programs for the Mentally Retarded .

I especially was impressed with your questioning of witnesses to deal with the trends and extent of the problems rather than to concentrate on individual "horror stories".

I am enclosing my testimony on the subject of the meeting and trust that it can be incorporated into the records of your Subcommittee.

I stand ready to provide any additional information your Subcommittee might require.

Sincerely,



Harold L. Flanagan
President
7103 Gateway Blvd.
District Heights, MD 20747
Phone (301) 735-2307

Enc.

P.S. In the second enclosure are actual scenes taken at the second largest institution for mentally retarded in Maryland, Great Oaks Center, 3100 Gracefield Road, Silver Spring, whose population of 220 includes 100 who are severe and profoundly retarded.

7103 Gateway Blvd. • District Heights • Maryland 20747

The Coalition Of Institutional Associations For The Mentally Retarded Of Maryland

An advocacy group of many parents, relatives, and friends of those unable to speak for themselves

April 6, 1993

My name is Harold L. Flanagan, President, The Coalition Of Institutional Associations For The Mentally Retarded Of Maryland. Our State presently has five institutions remaining with a population of 975. The State passed a Deinstitutionalization Bill seventeen years ago and has been downsizing the institutional population since that time. Presently the community living population is ten times the size of the institutional population. The community living population is principally composed of those who were institutionalized - with only a very small percentage coming from their own homes directly into the community living programs.

I attended over 80% of the State Hearings which took over eight months prior to the passage of the Bill. I vividly recall some of the reasons offered for deinstitutionalization. The major one being that residents at that time were denied a freedom of choice since the only system available was for those who were in State institutions. Another reason offered was that the cost of maintaining a resident in an institution was excessive and a greater population could be served by having them in community living programs. Another factor advanced was that the residents in institutions were limited in scope while community living programs offered their residents an opportunity to go into group homes, move to supervised apartment living quarters and eventually become members of the communities. Another was that members of the community living programs would be enrolled in supervised sheltered workshops and when they became proficient in their skills would be transferred out into the business communities.

Seventeen years later we find that these promises have not become realities. The freedom of choice is denied to those who would desire institutional living by the advocates for community living programs - whose aim is to close down all State institutions for the Mentally Retarded in Maryland. The cost of maintaining a resident in a community living program has rapidly risen with the cost of residences being affected by the escalation of real estate prices. Additionally the movement of residents from group homes to supervised apartment living quarters and then eventually into the communities has been minimal. Those residents who have become proficient in tasks in the sheltered workshops have been retained there so that the sheltered shops would benefit financially from these projects.

7103 Gateway Blvd. • District Heights • Maryland 20747

-2-

When the deinstitutionalization began there were many likely candidates in the institutions who could adapt to the greater freedom of community living programs. Presently those remaining in the State institutions have severe behavior and medical problems which the community living programs have not been able to cope with. Examples of that condition were found when the State was unable to meet downsizing goals because they could not find providers who would accept those challenges. The State likewise encountered problems when providers returned residents who they found they were unable to cope with the residents' needs. I personally experienced such a condition when my son was sent out twice for probationary periods and finally returned to Great Oaks Center, the second largest State institution, where his needs continue to be met.

I especially would like to comment on the dramatic visual presentation made by Mr. Jay Klein, The Institute on Disabilities, University of New Hampshire, Durham, New Hampshire, at the Subcommittee meeting. As you will recall the presentation was dramatic in portraying the differences of individuals while they lived in institutions and then became members of community living programs. Unfortunately, to bring about this dramatic effect "Hollywood License" had to be taken by showing the worst of institutions of the past and contrasting them with the best of community living programs of the present. Having visited Maryland State Institutions in my position as President of the Coalition I defy Mr. Klein to find any in the State which compare with those shown in his visual presentation. It is unfortunate that advocates who want all institutions closed use the same tactics.

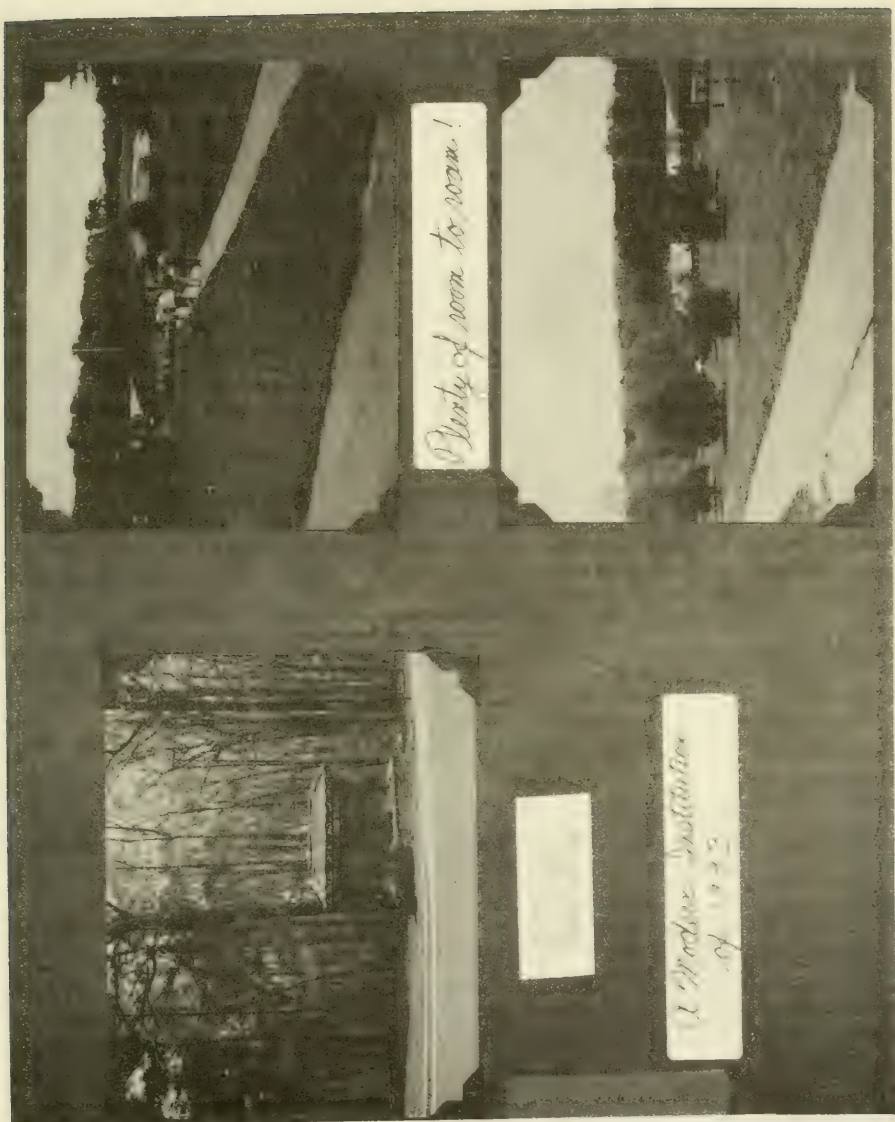
In reviewing the entire Subcommittee hearing I am once more reminded of the pattern that happened at the Maryland Deinstitutionalization hearings where great promises were made but have not become realities. I especially refer to the Chairman's questioning of witnesses about abuses uncovered and receiving replies that these were being "worked on" without any specifics given as how they would be corrected or what steps would be taken to prevent them from being repeated in the future.

While community living advocates are determined to set a date for the demise of institutions, they are reluctant to establish a time when they can really deal with all the severe and profoundly retarded remaining in the institutions.

-3-

MY CONCLUSIONS AND RECOMMENDATIONS

1. The United States Government examine in detail the characteristics of the residents remaining in institutions and determine if community living programs have the personnel, experience and resources to properly address the needs of all of that population.
2. The Federal Government, working jointly with State Governments, carefully analyze and ensure that adequate funding is provided to meet the residents' needs whether they reside in institutions or in community living programs.
3. Both Federal and State Governments establish surveillance systems to be assured that regulations are enforced and dangerous and questionable practices are detected and resolved before becoming major catastrophes for either the residents of institutions or community living programs.



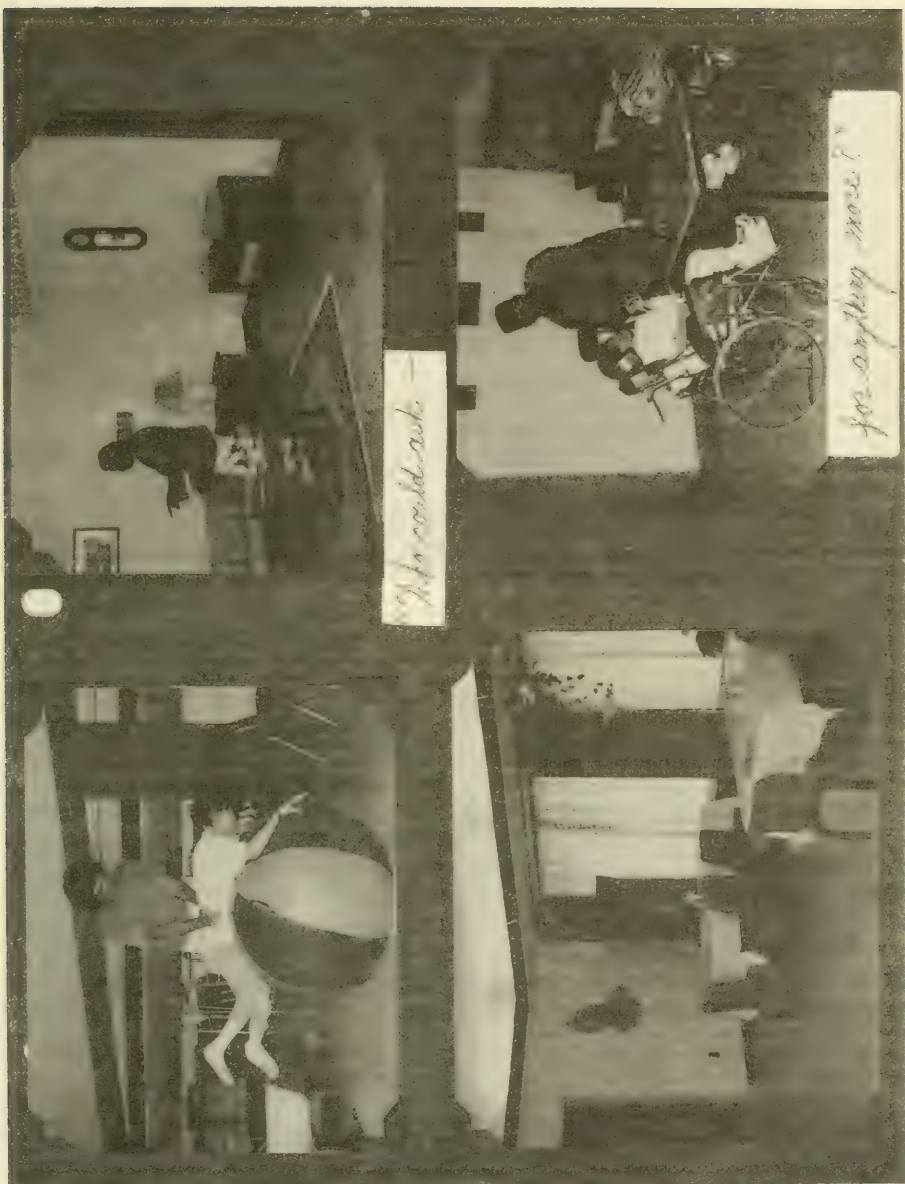
Plenty of room to roam!

For
2001
"The Goodbye" (2001)



*Pleasant surroundings
to relax in!*

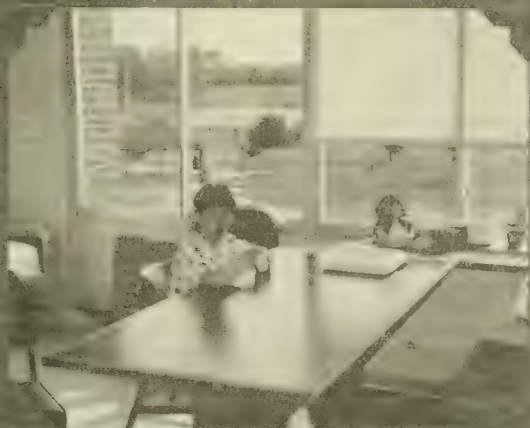




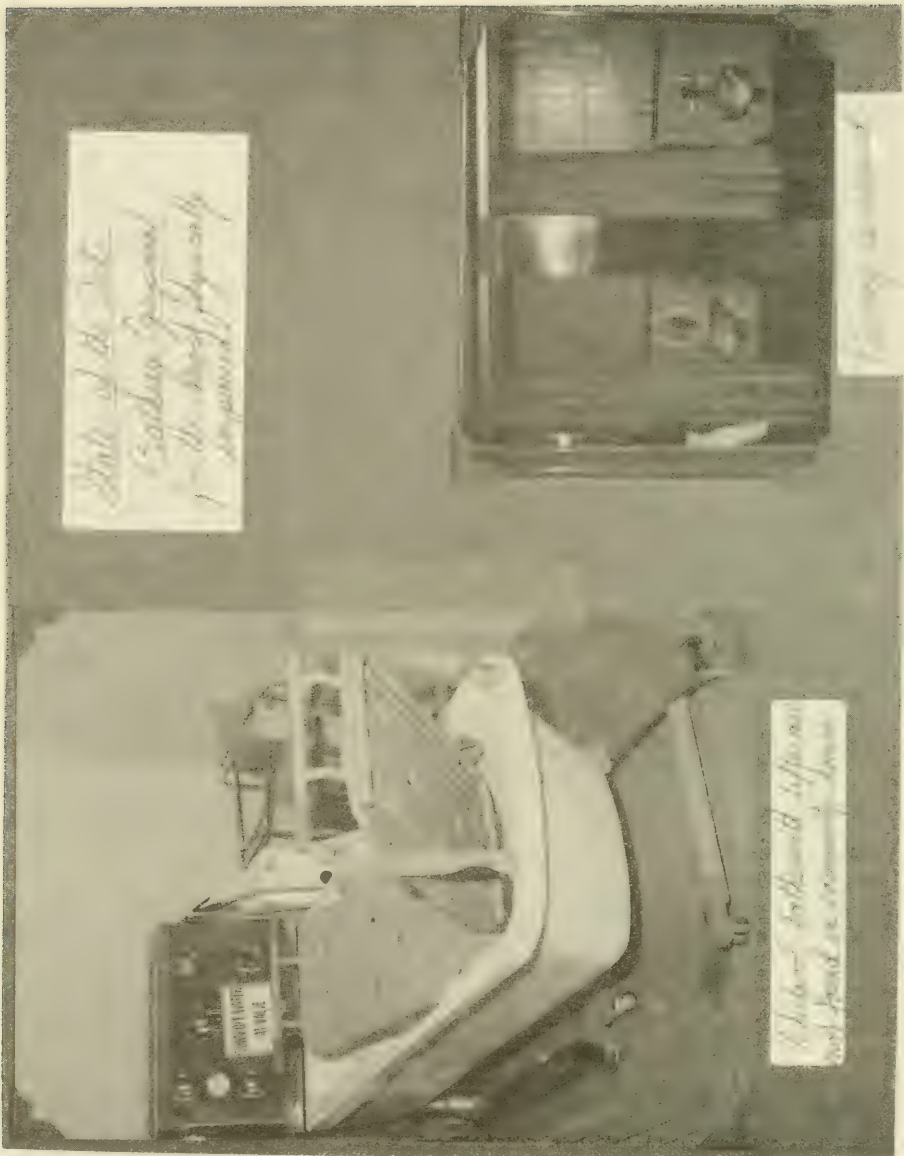




Private room



*2 people look during
a cooking class*



March 24, 1993

To: Congressman Ron Wyden
Washington, D. C.

From: Mr. and Mrs. Robert B. Cochrane
7075 S. W. Heath Place
Beaverton, Oregon 97005
(503) 643-2821

Dear Congressman Wyden:

Representatives from the community in our State will be testifying before your Committee regarding the problems we have experienced in Oregon with unprofessional providers who have also engaged, if not actively, then in a supportive role, in activities damaging to the MR/DD population for whom they are responsible.

One provider in particular, with quite extensive business in numerous other states, has been an example of fraudulent activities within this region. When its activities were investigated by a citizens group, intimidation and threats were leveled against those advocates as punishment for their inquiries. This provider agency has also been less than truthful as to the dispersal of their public monies and has repeatedly refused to give proper accounting to those families acting as legal guardians for their family members.

After a year of keeping careful watch on this provider agency, community advocates can say without a doubt, that it embodies all that is wrong with the growing proliferation of companies who see, in the country-wide downsizing and closure of institutions, a profitable enterprise not geared to the health, well-being, or dignity of its clients.

Our concerns also extend to the fact that State Agencies and its Mental Health Department are not aggressive in weeding out and barring these types of providers from its system.

Advocates, speaking to your Committee, will be specific in their own experiences which are not unique to Oregon. We all ask, "Where does our money go?" The fact that much of it goes straight into the hands of these less than desirable and often disreputable providerships underscores all that is wrong with the current policy of downsizing - at any cost.

Kathryn and Robert Cochrane

Robert B. Cochrane
Kathryn Cochrane

BW
NOV 04 1992

DRAFT

Draft Position Paper

RECOMMENDED FEDERAL POLICY DIRECTIONS ON
PERSONAL ASSISTANCE SERVICES
FOR AMERICANS WITH DISABILITIES

—
The Consortium for Citizens with Disabilities'
Task Force on Personal Assistance Services,
November, 1992

INTRODUCTION:

The Consortium for Citizens with Disabilities (CCD) is a working coalition of over 70 national disability groups. At its 1991 Annual Meeting in January, CCD established a Task Force on Personal Assistance Services (PAS). The Task Force's charge has been to develop recommendations for crafting comprehensive federal legislation to promote expanded and more equitable access to a full array of lifelong personal assistance services for Americans with disabilities of all ages.

WHAT IS PERSONAL ASSISTANCE?

Personal assistance is defined as one or more persons assisting another person with tasks which that individual would typically do if they did not have a disability. This includes assistance with such tasks as dressing, bathing, getting in and out of bed or one's wheelchair, toileting (including bowel, bladder and catheter assistance), eating (including feeding), cooking, cleaning house, and on-the-job support. It also includes assistance from another person with cognitive tasks like handling money and planning one's day or fostering communication access through interpreting and reading services.

THE NEXT CHALLENGE:

CCD and other disability organizations view the passage of comprehensive federal personal assistance services legislation as essential to realizing the full promise of the Americans with Disabilities Act (ADA). The ADA extends full federal civil rights protections in the private and public sectors in employment, transportation, public accommodations and communication to all of the Nation's 43 million citizens with disabilities. In doing so, in President George Bush's words, it is meant to "bring the shameful wall of exclusion tumbling down." For many, this wall will not fall on its own accord, however. An estimated 9 million Americans with varying disabilities require access to an comprehensive array of personal assistance services in order to truly make the promise of ADA a reality in their every day lives. This paper will present the Task Force on Personal Assistance Services' major findings and recommendations for developing comprehensive federal legislation to ensure greater, more equitable access to personal assistance services for Americans with disabilities throughout our Nation. Specifically, it will outline what the components of such legislation should be in regard to its eligibility, services, individual service planning, training, compensation, quality assurance, rights protection/due process and system design requirements. The Task Force expects to develop and disseminate a second position paper on preferred means for financing personal assistance services.

WHO SHOULD BE ELIGIBLE?

Any child or adult should be eligible for PAS who:

- (a) has a permanent or temporary physical, sensory, cognitive or mental impairment;
- (b) has an impairment which substantially limits one or more major life activities; and
- (c) requires personal assistance services as defined in the legislation.

The term "major life activities" should be defined to include every day tasks such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, remembering, concentrating, reasoning, information and stimulus processing, understanding, and working.

INCOME:

Individuals who meet the criteria set out above should be eligible for personal assistance services under this legislation regardless of their income. Any child or adult eligible for PAS whose income falls below 300% of poverty should receive such services at no cost. States may wish to charge eligible persons whose incomes exceed 300% of poverty for some portion of the services they receive based on a sliding scale. However, no eligible individual should pay more than 2% of their net income, after disability related expenses are deducted, on personal assistance services funded under this legislation. Additionally, no resource test should be applied to the nonincome assets or marital status of eligible individuals. Children under 18 years of age should be eligible for PAS on the basis of their own incomes and not the incomes of their parents. Cost-sharing requirements should be based on income adjusted for out-of-pocket disability related expenses.

PERSONAL ASSISTANCE SERVICES GUIDING PRINCIPLES:

A wide variety of personal assistance services should be made available to eligible individuals under a federal PAS statute.

Such services should be designed to:

- * be guided and directed by the choices, preferences and expressed interests and desires of the individual;
- * increase the individual's "control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities" (as called for in the National Council on Disabilities' Policy for Persons with Disabilities, 1983);
- * enable PAS users to select, direct and employ their own paid personal assistants, if desired;

- * enable PAS users to contract with an agency for these services, if desired;
- * foster the increased independence, productivity and integration of the individual into the community;
- * be easily accessible and readily available to all eligible persons where and when desired and needed;
- * meet individual needs irrespective of labels;
- * allow payment to family members for the extraordinary 'personal assistance they provide;
- * be provided in any setting, including in or out of the person's home;
- * be based on an individual services plan; and,
- * offer PAS users of all ages the opportunity and support needed to assume greater freedom, responsibility, and choice throughout life.

WHAT PERSONAL ASSISTANCE SERVICES SHOULD BE MADE AVAILABLE?

Personal Assistance Services funded under any comprehensive federal PAS legislation should include:

1. **PERSONAL SERVICES** including, but not limited to, those appropriate for carrying out activities of daily living in or out of the home including, but not limited to, assistance with bathing and personal hygiene, bowel and bladder care (including catheterization), dressing and grooming, lifting and transferring, eating (including feeding), giving medications and injections, menstrual care, operating and maintaining respiratory equipment and the provision of assistive technology devices and services;
2. **HOUSEHOLD SERVICES**, including, but not limited to, assistance with meal planning and preparation, shopping, light housekeeping, laundry, heavy cleaning, yardwork, repairs and maintenance;
3. **CHILD AND INFANT CARE ASSISTANCE** for eligible persons with disabilities who are the parents of children under the age of 18 meant to assist them in carrying out the functions of parenting at times when they would typically do so if they did not have a disability (e.g., assistance with diapering, feeding, lifting or transporting a child);

'extraordinary personal assistance services will be clarified in report language. That language will define these services to be those that are above/ and beyond the tasks that family members would perform for each other under ordinary circumstances. Criteria will be developed to define above and beyond. Finally, we will try to give an example of what we mean using a kid.

4. **LIFE SKILLS SUPPORT SERVICES**, including, but not limited to, assistance with money management, planning and decision making including computer assisted directions, home management, use of medications, following instructions, positive behavior management, companion or roommate services which provide regular supervision up to 24 hours for daily living, peer support, advocacy, and support for participation in social, community or other activities. Life Skills Support Services assist the individual to acquire, retain, regain, improve, or execute the self-help, socialization, decisionmaking, and adaptive skills necessary to achieve and maintain independence, productivity and integration and to live successfully in his/her home. These services can include training, prompting, cuing, support or substitute functioning;

5. **COMMUNICATION SERVICES** including, but not limited to, assistance with interpreting, reading, letter writing and the use of communication devices, augmentative communication devices and/or telecommunication devices;

6. **SECURITY-ENHANCING SERVICES**, including, but not limited to, monitoring alarms or systems and making or arranging for periodic contact in person and/or by telephone;

7. **MOBILITY SERVICES IN AND OUT OF HOME**, including, but not limited to, escort and driving, mobility assistance including on the use of public transportation;

8. **WORK-RELATED SUPPORT SERVICES** including, but not limited to, ongoing services to assist an individual in performing work-related functions necessary to obtain and retain work in an integrated work setting, and to fulfill the functions of a job and personal services on the job;

9. **SERVICE COORDINATION** including assistance with recruiting, screening, referring and managing personal assistants;

10. **ASSISTIVE TECHNOLOGY SERVICES**, including assistance with evaluating the needs of an individual in his or her every day environment; purchasing, leasing or obtaining assistive technology devices for use by individuals with disabilities; selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing such devices; coordinating and using other therapies, interventions or services with AT devices (e.g., those associated with existing education/rehabilitation plans or programs); training or technical assistance for an individual with disabilities or where appropriate the family; and training or technical assistance for personal assistants; and

11. **EMERGENCY SERVICES**, including substitute or back-up services for any of the above services needed on an emergency basis. Back up or substitute services shall be made available when usual PAS providers are unable to provide the service.

12. EDUCATION SERVICES, children and adults with disabilities needing PAS shall be offered such services as part of their right to inclusive education as well. Such education and PAS shall include age appropriate opportunities to learn to use and control PAS effectively.

Such services would be provided in addition to any other services to which the individual is entitled under the Rehabilitation Act, the Individuals with Disabilities Education Act, Title III of the Older Americans Act, Titles V, XVIII, XIX, and XX of the Social Security Act or other public programs or private insurance.

INDIVIDUAL SERVICE PLAN

An Individual Service Plan (ISP) should be developed in conjunction with each user of personal assistance services funded in whole or part under a federal PAS statute. To the maximum extent possible, each ISP should be based on the individual's self-assessment of their needs or that of their legally appointed representative and/or advocate.

The Single Point of Entry shall be responsible for:

- making an eligibility determination based on the individual's self-assessment or other user friendly assessments; and,
- working with the PAS user and/or their legally appointed representative and/or advocate to prepare a mutually agreed upon written ISP based on these assessments.

At a minimum, the ISP should identify and describe:

- the personal assistance services' needs of the user, including the extraordinary personal assistant needs of a child or minor with a disability;
- the type(s) and frequency of the personal assistance services which will be provided to the user under the PAS Program;
- the type and frequency of the services which will be provided to the user by alternate resources;
- the type(s) and frequency of needed personal assistance services which will not be provided to the user through any means (i.e., unmet needs);
- the timelines for providing PAS to the individual;
- the qualifications and/or skills required by a personal assistant to perform the services;
- to what extent the user is capable of, or willing to, assume responsibility for managing/coordinating their own services and what type of management training, if any, should be provided to assist the PAS user or their legally appointed representative and/or advocate to do so;

- the current PAS arrangements and protect by grandfather clause those relationships declared to be satisfactory by the PAS user with reasonable and periodic adjustments in hours, wages and benefits;
- the outcome-based measures of performance on which the quality of the service(s) will be evaluated, and
- the type and frequency of the quality assurance steps to be taken to ensure the effectiveness of these service(s) and the user's continued satisfaction with these service(s) and the personal assistant.

The ISP should be developed through a highly interactive process involving the PAS user and/or their legally appointed representative, and/or an advocate selected by the user and/or their legally appointed representative, the service provider(s), and the service coordinator. The PAS user may elect to be the service coordinator. The knowledge, life experiences, views and desires of the PAS user or their legally appointed representative, and/or advocate should be actively solicited and given full consideration throughout the assessment and ISP process.

When necessary, the ISP should be coordinated with other service plans such as the IFSP and IWRP. All efforts must be made to protect the confidentiality and privacy rights of PAS users.

The ISP should be reviewed and updated at least annually in an efficient, non-obtrusive, and economic manner, or at the request of the individual or their legally appointed representative, and/or advocate to reflect the needs of the PAS user. When circumstances require, the ISP shall be amended so that additional services shall be provided to address the changing needs of the user (e.g. injury, exacerbation of disability, illness or death of family member who provided PAS.) Disagreements arising from negotiations in the ISP development process should be resolved according to procedures described in the section on due process. PAS services should continue during any appeals.

STATE PLANNING AND PAS SYSTEMS DESIGN

Based upon the key concepts, principles and assumptions described in this paper, the minimum State planning and PAS systems design requirements should be as follows:

Lead State Agency:

A lead state agency should be designated by the governor or legislature to plan, develop, administer and coordinate and to accept full accountability of PAS programs, services and activities in each State. The legislation should make clear that this agency cannot be a medical/health agency. The responsibilities of the lead state agency should include:

- designating a single point of entry (SPE) in communities;
- maintaining a statewide (V/TDD) 1-800 PAS INFO Line to provide up-to-date date information on PAS services and refer individuals to the SPE and other resources in their communities;
- establishing procedures for program operations, including a process to enable funds to go directly to PAS users to hire their own personal assistants;
- creating incentives for private sector involvement, such as:
 - o comparable pay and benefits, unless state can justify otherwise
 - o preference for private providers which are user controlled;
 - o assistance to small private providers (e.g., in pooling to negotiate for goods and benefits);
- assuring uniform availability of PAS services throughout the state;
- preparing, in cooperation with the planning and advisory board, the State plan; and,
- establishing management assistance programs through contracts or other mechanisms to process FICA, tax withholding and other deductions of personal assistants.

Funds should be made available to pay for the agency's administrative costs associated with carrying out these and other related responsibilities.

Single Point of Entry:

The lead state agency should be able to designate/contract out with other public or private agencies to carry out the functions of a Single Point of Entry for PAS by 1) catchment area, 2) set population(s) and/or 3) set services.

To be designated by the state as a Single Point of Entry for applying for and accessing personal assistance services, an agency should be required to demonstrate the capacity and accept the responsibility to serve all those who need such services as well as to respond to multiple points of referrals.

Specific functions of the entry point would include:

- o intake
- o eligibility determination
- o conducting needs assessment/ service specificity
- o determining scope of services (hours, duration, etc.)
- o referral to providers
- o contracting for services
- o outreach initiatives, particularly to potentially eligible individuals

Such agencies also must be involved in interagency coordination, quality assurance, due process and all other aspects of PAS service delivery.

In order to be designated the single point of entry, an agency shall have a consumer controlled advisory council to guide it's activities and services. This council should be composed of 50%+ of PAS users and their families or representatives and broadly representative of the disability community.

Systems Change Incentives

The legislation should require that each State establish a state policy board on personal assistance services, which should be:

- o composed of at least 60% of PAS users and their families or representatives (2/3 are PAS users adn families or minor children, 1/3 are families or representatives or individuals not represented above)
- o broadly representative of the disability community
- o geographically representative
- o include members from affected state and local agencies
- o appointed by governor, with advice/nominations from the disability community
- o independent of the lead agency

The policy board should jointly develop the state plan with the state agency, and oversee implementation as well. It should be a staffed body and preference should be given to the hiring of qualified (cross disability trained) users of personal assistance services. Additionally, non-governmental members of the board who are not otherwise paid to perform duties associated with the board, should be reimbursed on a per diem basis. The per diem should include the salary, travel and other expenses of the member and those of their personal assistant(s) if applicable.

The PAS policy board also should take the lead role, in cooperation with the single state agency, in developing user-friendly policies that:

- o ensure widespread cross disability outreach and involvement in all aspects of the design, delivery and evaluation of PAS programs, services and activities, including training, throughout the State
- o create and require the use of user satisfaction standards and life outcome measures in all aspects of the State's PAS Quality Assurance efforts
- o prohibit the denial of services based on an applicant or PAS user's type or level of disability
- o promote cost-effective administration and other cost savings in the design, delivery and evaluation of PAS services
- o foster decision-making by PAS users in the design and delivery of PAS services
- o create and foster the use of a PAS conflict resolution process
- o promote the pooling of purchased goods and benefits
- o maximize private sector utilization

- o create, foster ~~and assess~~ the use of a direct subsidy option to provide PAS users the choice of purchasing their personal assistance services directly
- o eliminate or reduce ~~the~~ need for segregated, facility based care
- o require outreach efforts by Single Point of Entry agencies to ICF/MR's and nursing home facilities to ascertain need/availability of personal assistance services throughout the State

The PAS legislation ~~should~~ authorize the use of higher federal matching share as an ~~incentive~~ to eliminate or reduce the use of segregated, facility based care and instead provide individuals in segregated facilities with needed personal assistance services in their own homes and communities. The legislation should consider size of the institution and length of stay in regards to this provision. It also ~~should~~ require that each State PAS planning and advisory board hold a minimum number of meetings per year at a variety of convenient ~~and~~ accessible sites throughout the State.

Public participation, ~~es~~pecially by PAS users and their families or representatives, in ~~the~~ workings of the board is essential. It should, therefore, be widely encouraged and a required part of each board meeting. Adequate public notice should be given for each meeting in a variety of accessible formats.

State Planning

The PAS legislation ~~should~~ require that each state develop a consumer-driven long-range 5 year plan, updated annually, on all aspects of the design, delivery, evaluation and future directions of PAS programs, services and activities in the State.

The single state agency should be responsible for preparing the State plan. Each state plan shall specify the timelines for it's implementation. The public, particularly PAS users and their families, must be involved in the development and revision of the plan. Feedback from quality assessment and consumer satisfaction assurance activities must be used in revising the plan annually.

Each plan should clearly describe and provide adequate assurances that the State has the sufficient capacity, user-friendly policies and practices in place to ensure uniform availability of PAS services throughout the state by providing for:

- o individualized services
- o cross disability coverage
- o life span coverage
- o statewide coverage
- o recruitment, referral, outreach and training systems
- o staffing and staff training
- o public participation
- o quality assurance

Each State plan should specify how funds may be spent and further delineate lines of responsibilities regarding all aspects of the design, delivery and evaluation of PAS programs, services and activities.

TRAINING ON PERSONAL ASSISTANCE:

Under a comprehensive federal Personal Assistance Services statute, Federal financial assistance for PAS skills training should be made available by the State lead agency. PAS users, and where appropriate, their legally appointed representatives and advocates should be informed of, and provided such value- and competency-based training on PAS upon request. PAS users, their families and advocates should be involved in every aspect of training, including the design of the training curriculum, training materials, and the delivery of training. The policy board should review these training programs.

Towards this end, States should provide assurances that, to the maximum extent possible, all such training is:

- reflective of and responsive to the preferences and expressed interests of individuals with disabilities;
- developed, designed, delivered and evaluated by qualified PAS users; and,
- provided by disability consumer organizations and other qualified agencies.

TRAINING FOR USERS OF PERSONAL ASSISTANCE SERVICES:

States should make available to each PAS user training in their roles, responsibilities, and rights as a manager and/or consumer of personal assistance services. The need for training should be described in and carried out as part of the user's Individualized Service Plan.

The training shall be provided in the primary language of the user. All materials shall be provided in an accessible format when needed.

Specifically, PAS management training should be made available to users to assist them to acquire and improve their skills in regards to scheduling, training, supervising, compensating, evaluating, disciplining, and discharging PAS workers. Similarly training also should be made available to users in quality assurance to assist them in defining quality life and service outcomes, evaluating the quality of the services, recognizing inappropriate and poor quality services, including neglect and abuse, and how to use the appeals process. All such training should be provided in the media, language, materials, and format which is best suited to meet the consumer's needs. A PAS user may waive their right to receive such training.

If an adult PAS user cannot fully benefit from this trainings or the user so directs, his/her legally appointed representative(s) and advocate(s) should be informed of and provided training upon request. When a child requires PAS, the personal assistant should be responsible to the parent/guardian until the child reaches the age of majority. Such parents should be informed of and provided upon request, training designed to assist the child, with his/her assistant, to assume increased freedom, responsibility, and choice as s/he grows.

TRAINING FOR INDIVIDUALS WHO PROVIDE PERSONAL ASSISTANCE:

An introductory orientation to PAS should be required for all individuals who provide personal assistance unless waived by the individual with a disability or the individuals who provides personal assistance has demonstrated experience. The orientation should emphasize to the individual who provides personal assistance that their purpose is to assist an individual with a disability to achieve self-determined goals.

This orientation for individuals who provide personal assistance should be value-based and include information on:

- disability as a natural human condition;
- the philosophy of independent living;
- the principles of community integration;
- the dignity of risk;
- the role, rights, and responsibilities of PAS users;
- the role, rights, and responsibilities of personal assistants; and,
- the appeals process.

The training and orientation shall be provided in the primary language of the provider. All materials shall be provided in an accessible format when needed.

States should make available additional training on an individualized, as needed basis. The need for such training of an individual who provides personal assistance should be described in and carried out as part of the Individualized Service Plan. Federal legislation should further specify that a PAS user may require that personal assistance providers be trained in the skills required to meet the services called for in the ISP. Moreover, the PAS legislation should require States to review, revise and waive nurse practice act requirements which unnecessarily hinder personal assistants from being trained and/or carrying out their responsibilities.

PAS PROVIDER COMPENSATION AND RELATED ISSUES

In order to assure high quality in services, a federal PAS statute should require that personal assistants are meaningfully compensated for their labors and receive fringe benefits comparable to those available to other para professionals in similar fields.

The compensation of personal assistants should be meaningfully related to such factors as:

- the required skill level of the personal assistant as specified in the person's ISP;
- the education and training required of the personal assistant
- the geographic area and local labor pay rates;
- the duties and skills required by the ISP;
- the length of service/experience of the personal assistant; and,
- night and weekend shift differentials.

Compensation for full-time assistants should include traditional employee benefits, e.g., health insurance; sick and annual leave; FICA; workers' compensation and unemployment insurance. In addition, assistants should have liability insurance coverage. Benefits for part-time workers should be prorated to their hours worked. States should be required to establish mechanisms (e.g., benefits pools) for fringe benefits to assist individual providers and small employers to acquire benefits at a reasonable cost. The legislation should encourage States to provide additional benefits to PAS providers which are available to state employees, including: Retirement; Professional development; Employee credit unions; and, Disability Insurance.

The legislation should also provide incentives to the States to investigate, develop and implement promising and innovative approaches for:

- determining the compensation rate for ISPs requiring different levels of skills, experiences and training;
- encouraging PAS users and their personal assistants to develop and maintain positive, productive and enduring working relationships as a means of preventing abuse and neglect, high turnover rates and burnout;
- enhancing career opportunities for personal assistants in ways which encourage individuals to remain in the PAS field.

For PAS users who rely on management assistance, recruitment, screening, and referral services, there should be up-front criminal background checks and job-interview screening to determine the general qualifications of those seeking personal assistance positions. PAS users should be able to assume that basic quality measures have been met, including that the applicant or service

provider has been screened and that he/she is, in fact, qualified to do the job. Finally, States should establish mechanisms and funding resources to develop and maintain a cadre of trained personal assistants who can provide PAS to users on both an on-going and emergency basis.

QUALITY ASSURANCE

The federal PAS statute should include requirements for States to develop and implement a system of quality assurance to foster quality and excellence in every aspect of the design, delivery and evaluation of user responsive personal assistance services. Such a system of quality assurance should be premised upon the following major assumptions and guiding principles:

1. Quality is defined best in terms of the individual, based on desired life outcomes that the person, their legal representative and/or advocate, recognize as important.
2. These outcomes can include integration into one's community, participation in desired activities, increased mobility, more efficient daily living, enhanced communication, general well-being, self-direction, productivity, employment, or an increase in social skills. (Note: An individual need not demonstrate an ability to achieve a particular life outcome to recognize it as important or to work towards it.)
3. It is impossible to ensure a total absence of abuse. However, abuse, neglect and exploitation of individuals with disabilities can be significantly minimized and prevented by:
 - promoting quality services;
 - fostering maximum self-determination;
 - recognizing the dignity of risk-taking;
 - ensuring that safeguards are in place to identify and respond immediately and effectively to instances of abuse, neglect or exploitation;
 - screening of PAS providers;
 - providing information on abuse, neglect and exploitation as part of the orientation;
 - training PAS providers; and
 - training PAS users as needed.

State PAS Quality Assurance systems should develop and put in place user-friendly policies and practices that:

- affirm that PAS users must drive all aspects of the process;
- ensure that QA is recognized as a prime consideration in every step involving the requesting, offering and providing of PAS;
- affirm that PAS users must be assumed to be able to be independent*, unless demonstrated otherwise
- recognize QA as an on-going individualized and comprehensive assessment of services in relation to the desired outcomes of the PAS user or their legally appointed representative, and/or advocate;
- ensure the person is satisfied with the quality of the service(s) provided;

- take a pro-active approach, anticipate, respond to and solve problems and challenges in a manner that does not go beyond the need of the individual for support;
- provide for a system of "early warning signals" for identifying and remedying current or potential problems (e.g., excessive staff turnover);
- ensure that each individual's ISP has a QA component in it specifying the type/level of QA support and assistance to be in place (e.g., drop-in visits, natural supports and citizen advocacy services);
- ensure that if problems are discovered, it triggers a remedy and, if warranted, a re-examination of the QA component of the individual's ISP;
- provide for background checks and job-interview screens to determine the general qualifications of those seeking personal assistant positions;
- ensure that the service provided meets measurable standards of quality and apply to family and non-family providers of PAS, as appropriate;
- provide incentives for best practices and sanctions for undesirable practice; and,
- provide for enhanced QA support and assistance to people who are at-risk or particularly vulnerable to abuse, neglect or exploitation.

* PLEASE NOTE: This use of this term is consistent with the definition of "independent living" developed by the National Council on Disability as being "control over one's life based on the choice of acceptable options that minimize reliance on others in making decisions and in performing everyday activities" (National Policy for Persons with Disabilities, 1983). In its 1986 Report, Toward Independence, the NCD further comments that: "Living independently includes managing one's affairs, participating in the day-to-day life of the community in a manner of one's own choosing, fulfilling a range of social roles including productive work, and making decisions that lead to self-determination. Community-based services that promote such independence for Americans with disabilities constitute one of the most promising service delivery strategies for our Nation." p.43.

It is critical that PAS users be given the support they need to gain, maintain and improve competencies and skills required to exert greater control over their own lives. In many instances, this should include providing management training or support to assist a person in having as much effective control over services and personnel as possible. Whenever necessary, assistance should be provided to enable an individual to be more self-directing and/or to assist him/her to maximize his/her interaction with his/her personal assistant. If an user requires or requests an advocate, the primary role of that advocate should be to elicit and advocate for their views, choices and preferences of the individual with a disability.

The State system must have varying levels of quality assurance support because individual abilities and preferences regarding quality will vary. Available support levels should be sensitive and responsive to factors such as the nature/level of one's disability; life experiences; individual needs and preferences; communications

abilities; willingness, interest or capacity in playing a significant role in assessing quality; and those supports necessary to enable a quality assurance role.

Moreover, each State's PAS QA system should provide for independent assessments of quality and consumer satisfaction. PAS users, their families and advocates should be involved in every aspect of designing and carrying out these assessments. Such assessments should be made by persons or organizations independent of the service provider or the state. Each independent assessment should include a review of life outcome measures and the review of quality must be linked to the outcomes. The timing of such assessments may vary based on individual need, but at minimum, must be annual or semi-annual as indicated in the ISP. Assessments also must include solicitation of the consumer's suggestions for improvements. Additionally, in-home assessments of service delivery must focus on the service being delivered.

Finally, in regards to State Planning requirements, each State's plan should clearly describe the ways in which PAS quality assurance program will fit into the overall system while still retaining its independence. The State Plan also should define and describe what role(s) the Protection and Advocacy system, the Independent Living Centers, the Developmental Disabilities Planning Council, Area Agencies on Aging, child protective services and other public/private entities should play in PAS QA efforts. Moreover, States should be required to use feedback from quality assessment and user satisfaction surveys in revising the plan annually. This approach should be flexible enough to encourage best practices to develop.

ASSURING RIGHTS PROTECTION AND DUE PROCESS

The following are the basic rights protection and due process procedures that should be established under a federal PAS statute:

An Established Appeals Process:

The PAS legislation should establish a basic appeals process similar to those in IDEA and the Rehabilitation Act which would be used to resolve any disputes between an individual with a disability and any State entity, program or individual providing personal assistance services to the person. While both IDEA and the Rehab Act include procedural safeguards intended to ensure the impartiality of the hearing process, the actual implementation of these provisions often falls short of the overall intent. Hence, the appeals process adopted for PAS should include the current procedural safeguards found in these two laws and some additional safeguards as well. Specifically, PAS legislation should include the following provisions.

- 1. Purpose of the Appeals Process --** The legislation should clearly state the purpose for establishing the appeals process.

2. Informing Affected Individuals -- All persons seeking or receiving services funded under the legislation must be informed of the procedural safeguards available under it. This notice should include the names and addresses of the individuals or agencies with whom appeals may be filed. It also should include the name(s) and address(es) of the Protection and Advocacy System(s) where they may obtain advocacy or legal services and/or assistance. This information must be provided during all PAS orientation, during the development of the ISP and at each ISP review.

3. Notification of Change in Service Status individuals receiving services must be given a timely and adequate written notice prior to changing, reducing or terminating services. Such notice must explain the reason for the change and an estimate of the date that the change will occur.

4. Issues an Applicant or PAS User Can Appeal --The legislation should identify the actions, issues, and circumstances which an individual can appeal.

5. Informal Review -- It should permit the development of an informal and voluntary administrative review process if it is likely to result in a timely resolution of disagreements in particular instances. However, it should further make clear that this process may not be used as a means to delay a formal hearing unless the parties agree to do so. The choice of whether to use this approach needs to rest with the applicant or PAS user.

6. Mediation/Negotiation -- The legislation should encourage but not mandate that an attempt be made to mediate or negotiate a resolution between the individual with a disability and any State entity, program or individual providing personal assistance services to the person. Decisions affecting when and whether to mediate a dispute shall be made solely by the PAS user or other authorized representative.

7. The Minimum Formal Review Procedures -- The legislation also should clearly delineate the minimum requirements that must be met by any formal review process that is used to resolve conflicts which arise between individuals with disabilities and the programs that provide them personal assistance services funded under it.

These minimum requirements should:

--mandate the use of impartial hearing officers in any formal review procedures;

-- establish minimum requirements for serving as an impartial hearing officer; and,

-- ensure that a hearing is held to investigate and resolve any conflict involving the requesting, offering and providing of personal assistance services, within 45 days of a request by an applicant or PAS user.

The rights protection and due process section should further direct States to develop and put in place user-friendly policies and practices that:

- specify that an applicant or PAS user or, if appropriate, the individual's parent, guardian, or advocate, must be afforded an opportunity to present evidence, information, and witnesses to the impartial hearing officer;
- assure an applicant or PAS user of their right to be represented by counsel or another advocate, and to examine all witnesses and other relevant sources of information and evidence; and,
- prohibit the introduction of any evidence at the hearing that has not been disclosed to the individual with a disability at least five days before the hearing.

The impartial hearing officer should be required to make a decision based on the provisions of the law, governing regulations, and, if applicable, the State Plan for PAS, and provide the individual with a disability or, if appropriate, the individual's parent, guardian, or other representative, and to the Director of the service providing agency a full written report of the findings and grounds for the decision within 30 days of the completion of the hearing. The individual with a disability must be provided the final decision of the impartial hearing officer in an accessible format. Upon request, the individual must be provided with a record of the hearing in an accessible format.

Similarly, the rights protection and due process section should make clear that any accommodations necessary to ensure the full participation of the individual with a disability or, if appropriate, a parent, guardian, or other representative at any stage of the due process procedures should be provided at public expense. This would include such things as ASL interpreters or interpreters fluent in the primary language of the individual.

In addition, each hearing involving oral arguments must be conducted at a time and place which is reasonably convenient to the parties involved. The impartial hearing procedures should provide for reasonable time extensions for good cause shown at the request of one or both parties.

8. Conditions for Continuing Services Pending an Informal Review or a Formal Hearing. All services called for in an user's ISP shall be provided to the individual throughout the appeals process.

9. Private Right of Action -- Any party aggrieved by the findings and decision made by an impartial hearing officer should have the right to bring a civil action in any state court of competent jurisdiction or in any district court of the United States within four months of the date of the issuance of the hearing officer's written decision.

10. Utilizing An Existing Protection and Advocacy System to Resolve Disputes --The legislation should also provide incentives to States to develop and implement innovative approaches utilizing existing P&A systems in investigating and resolving disputes involving the requesting, offering or providing of personal assistance services.



May 11, 1993

Representative Ron Wyden
Rayburn House
Rm. B 363
Washington, DC 20515

Dear Rep. Wyden:

I am writing to you on behalf of The Mental Retardation Providers' Council (MRPC), a group of 85 Massachusetts providers of community residential services for people with mental retardation and other developmental disabilities. We are writing in response to the House Subcommittee on Regulation, Business Opportunities, and Technology's request for information about developing a system that will better meet the needs of this population.

As providers, we strive to create services for individuals with disabilities that are tailored to the individual's needs and allow for the optimum amount of individual choice. As our service system has evolved, we have moved from the horrific conditions of institutional settings to numerous types of community group living alternatives. In the past few years, we have focused on creating services that the individual desires rather than "plugging" people into existing models of programs. While several instances of provider mismanagement have been cited within our state, most providers operate within the established regulations and provide quality services.

We share your committee's concerns about the physical abuse of individuals with mental retardation. The problem of violence and abuse permeates our culture. These individuals are especially vulnerable, and often not able to defend themselves or even communicate about what happens to them. Most of the direct service jobs in this field--which in truth require great skill and dedication to be done well--are filled by underpaid, undertrained people who often do not share a positive ideology or values. This leads to a great deal of staff turnover. We must increase the salaries of these workers to attract better qualified staff. Money needs to be made available so that individuals can be trained properly before they begin working with consumers. We need to encourage providers as well as individuals to report instances of abuse without fear of retaliation.

Within Massachusetts, we have numerous monitoring agencies and quality assurance systems. We do not need further regulations which will increase our paperwork. We need a comprehensive system of Total Quality Management which starts by looking at what the consumer desires and sets realistic performance outcomes for providers.

If you have further questions, please don't hesitate to contact me.

Sincerely,

Diane Iagulli
President, MRPC

217 South St., Waltham, MA 02154 617-891-7327 Fax 617-891-6271

The Community Personnel Study:
Turnover Issues In Mental Retardation Community Programs

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Massachusetts Department of Mental Health
Division of Mental Retardation
March 27, 1981

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PREFACE

The Community Personnel Study, conducted by the Department of Mental Health during the past 8 months, was designed to quantify the scope of staff recruitment and retention problems, and identify the most critical factors that affect these problems. The Study was charged with developing recommendations that would address these issues.

In November, 1980, the Department of Mental Health distributed an Executive Summary of this study which presented the major findings emerging from this research.

The Community Personnel Study represents the first attempt of the Department of Mental Health to quantify and analyze a broad range of personnel factors in community based mental retardation programs. The data collected for this survey is one of the first such efforts in the United States. It is our hope that this study will provide a broad understanding of the pertinent issues and serve as a foundation for future research in this area.

INTRODUCTION

2.

Community programs are experiencing grave difficulties in the recruitment and retention of qualified staff, particularly at the direct service level. This issue is especially serious for residential programs, where the inability to develop a stable workforce endangers both the quality and continuity of client services. Day programs, while somewhat better off, are losing experienced and veteran staff, a troublesome problem in maintaining quality rehabilitative programs for clients.

The issues that emerged from the Community Personnel Study consist of an intricate inter-relationship of the most salient factors bearing upon employee recruitment and retention. These include adequate and competitive salaries, a reasonable number of required hours of work, compensation for extra hours of required work, fringe benefit provision, the opportunity to enjoy holiday benefits, the opportunity for personal and professional growth, and career mobility. In addition to these concrete factors, issues such as communication within the organization, input to policy and decision making, input to client service plans, feedback, and quality of supervision received emerged as factors contributing to a productive work environment.

Considerable attention has been devoted to understanding the problems of staff turnover in recent years. Not only has the Department of Mental Health explored this issue in depth at its state schools (Coleman 1979), but private industry and academic researchers are focusing on turnover as a major consideration in organizational health and efficiency. The results of a variety of studies in which turnover has been a consideration (Porter and Steers, 1979), indicate that the basic causes can be traced to four functional areas:

1. compensation,
2. applicant selection (recruitment),
3. supervision and training; and
4. job structure.

These findings are in harmony with the fundamental conclusions that have emerged from the Community Personnel Study.

Compensation is perhaps the most evident element in employee motivation and job satisfaction. It is, however, very easy to view compensation in an overly simplified manner. Research on compensation (Heneman, Schwab, Fossum and Dyer, 1980) indicates that there is a complex interaction among the factors of work performance, satisfaction, and compensation. Without addressing other aspects of the work environment, compensation alone may be an inadequate response to the problem of turnover.

Research findings (March and Simon, 1958) point to two critical points that must be faced in considering the role of pay in employee turnover and motivation:

1. Pay must be equitable. If employees believe, with good reason, that they are not receiving fair treatment from the organization in exchange for the responsibilities placed upon them, dissatisfaction and ultimately turnover will result. Uncompensated overtime work and hours of work that are above and beyond a regularly scheduled work week appear to be major factors in employees' determination of equitable pay.

2. Pay must be competitive. While an employee may be enthusiastic about his job, supervisor, and organization, it is only reasonable to expect that, if the individual has marketable skills, he will be under considerable pressure to change jobs to receive a better salary. This appears to be increasingly true for individuals with skills in the human services area, where competition for employees is becoming more pronounced each year. When pay differences reach major proportions, other factors begin to lessen in importance.

In summary, then, a fair, competitive compensation program is basic in keeping turnover within acceptable limits.

Recruitment and applicant-job selection is the most direct intervention strategy usually available to an organization to combat turnover (Wanous, 1973). In state schools, attention has been devoted to improving the recruitment and orientation procedures that are being employed, one of several factors that have contributed to the overall improvement in the personnel situation at these facilities. Attention to job-applicant match is an important step in the long term strategy for developing a stable workforce.

The first step for addressing this issue in the community system is to achieve a competitive position for recruiting in the available labor market. This will help to correct the present situation, where either the quality of job applicants is below acceptable standards, or those applicants who meet the quality standards refuse the job opportunity because of non-competitive compensation and excessive hours. Concomitant with this step will be to develop more professional and effective methods to attract and recruit qualified personnel.

The third functional area that appears to affect turnover is concerned with the supervision received by employees and the quality of the training employees receive to equip them to properly fulfill the responsibilities of their job. Research has demonstrated a clear relationship between the quality of supervision and the work performance and job satisfaction of those employees being supervised (Zaharia and Bayneustern, 1978). Research has also indicated a significant relationship between the degree to which the employee is prepared with the skills needed for the job and job satisfaction (Louis, 1980).

The need for training, consequently, can be seen as consisting of two related areas: first, training for supervisory staff to improve the quality of the supervision exercised, and thus improve employees' job performance; and second, training to improve the quality of skills that employees need to effectively perform the functions that are required on the job.

The final functional area that relates to turnover concerns the nature of the job structure. Documented evidence shows that at all levels of job content, employee involvement in the issues that significantly effect the nature of the job contribute to lower turnover and improved job satisfaction (Freudenberger). Although this area was not a specific focus of the Community Personnel Study, a significant amount of interview data concerned issues such as employee input to policy and decisions and other similar issues that affect the employees' job. This area is one that warrants further research.

METHODOLOGY SUMMARY

The Community Personnel Study consisted of 7 different areas of inquiry and data collection :

- *1. Turnover data was collected from all Department contracted community mental retardation programs in a representative sample of 10 of the 41 areas in the state. This sample involved 4 of the 7 Department regions.
2. Salary and benefit information was also collected from this sample of programs.
3. Data on functional job titles, current salaries, MR experience and hours worked were collected from all Department contracted vendors in the state as part of the Department's FY'82 Adequacy Request.
4. In-depth interviews were conducted with 125 staff at all levels of vendor organizations and the Department's Area and Regional Offices.
5. 71 randomly selected human services programs outside the Department system were surveyed for turnover and salary information. This survey also included in-depth interviews with staff throughout the programs involved.
6. A survey of other states was conducted to develop data concerning salaries and benefit provisions throughout the country and to assess the various strategies utilized in other states concerning community based human services programs.
7. A survey of research literature was conducted to better assess the current status of turnover and retention efforts.

A detailed description of the specific methodology employed in each area of the Personnel Study is provided at the beginning of the appropriate section of the report.

*Region I-Berkshire, Franklin-Hampshire, Holyoke-Chicopee
 Region II-Worcester
 Region V-Attleboro, Plymouth, Taunton
 Region VI-Bay Cove, Harbor, Mass. Mental

A particular concern of the Personnel Study was that the 10 area sample population for the survey be representative of the Department of Mental Health's 41 areas across the state. The population of the areas, the unemployment rate, and per capita income were the variables used to verify that the Community Personnel Study sample reflected the Commonwealth as a whole. Appendix 1 presents a summary of the sampling statistics.

1. Population Density: Approximately sixteen percent of the population of the Commonwealth resides in rural areas with population density per square mile less than 500. The proportion of the sample population residing in rural areas is twelve percent. Two of the ten areas included in the study are rural areas; eight of the forty one total areas in the Commonwealth are rural areas. Approximately forty two percent of Massachusetts' population reside in areas with a population per square mile between 500 and 2000; forty eight percent of the sample population are included in this density grouping. Twenty of the forty-one DMH areas have this population density while five of the ten areas included in the sample have this characteristic. Three Region VI urban areas--Harbor, Bay Cove, and Mass Mental--were included in the Community Personnel Study sample. The city of Worcester was among the sample areas, to ensure that an urban area outside of Boston was included.
2. Unemployment Rates: The Division of Mental Retardation recognizes that recruitment and retention can vary with unemployment conditions in areas throughout the state. Rather than attempting to correlate the results of the study according to unemployment rates, the sample areas were chosen to reflect unemployment conditions among all cities and towns of the Commonwealth, thus enabling us to draw conclusions that relate to all DMH areas in general.

The overall unemployment rate in the Commonwealth estimated for May, 1980, was 5.57; the average unemployment rate weighted according to populations of respective towns or cities in each area is 6.03 among the ten sample areas. The range of unemployment rates for all areas in the state is a low of 3.6 in the Concord area to a high of 8.43 in the Blackstone Valley area. Among the sample areas, the low is 4.45 in Worcester; the highest 6.9 in both Plymouth and Taunton.

3. Per Capita Income: Per capita income in all Department of Mental Health areas varies according to a standard deviation of \$1004.50. The average 1977 per capita income among all areas was \$6032.06. The weighted average for the ten area sample is \$5393.70, which falls within one standard deviation of the population.

On the basis of the three measures presented above, it can be seen that the 10 area sample utilized in the Community Personnel Study is representative of the Commonwealth as a whole on the basis of population density, unemployment, and per capita income. These three measures identify significant variables which bear upon overall recruitment and retention.

ANALYSIS OF TURNOVER DATA

Employee turnover in Massachusetts' MR Community programs has, to date, been an unquantified problem. Although turnover has long been a primary concern of the private sector, public institutions have only recently begun to recognize its effects. Yet for human service organizations, turnover not only reduces the efficiency of the organization, but more importantly, also seriously affects the quality of the services delivered to clients.

The effects of turnover can be clearly seen in four areas: a) the disruption of program continuity, b) the continuous lack of adequate numbers of staff, c) a disproportionate amount of staff time spent in the hiring and orientation process, and d) the expenditure of funds for replacing staff (Coleman, 1979). The economic implications are enormous. Although no price tag can adequately represent turnover's impact on client habilitation, organizational costs have been documented. From costs involved in recruiting, selecting and training to those incurred by having large numbers of inexperienced people in jobs, turnover is expensive. It has been estimated that the cost of replacing one direct care staff person at an MR institution is approximately \$2,000 (in 1980 dollars) (Coleman, 1979). Although no similar projection has been made for staff in community programs, one can nevertheless begin to envision the magnitude of the dollars involved.

Methodology

The systematic measurement of employee turnover in Massachusetts' MR vendor agencies is a task of no small proportions. For this study, turnover data was collected in agencies of the ten geographic areas listed previously.

Each agency quantified the movement of its employees for fiscal year 1980 in two-month segments (July/August 1979, September/October 1979... May/June 1980). The data was aggregated according to the following staff variables: number of positions at the beginning and end of each period, number of vacancies at the beginning and end of each period, and number of new hires, terminations, applicants and dismissals during each period. Each variable was selected to monitor a key facet of employee movement. The composite picture enables one to analyze movement into and out of an organization, and to examine staffing levels at discrete points in time.

Analysis and Discussion

The indices employed here were derived from turnover theory that has been utilized both in industry and in the public sector (Ganju, 1979). Traditionally turnover is considered in terms of the proportion of employees whose service is terminated in a specified time period to the average number of employees during the period. The formula used in calculating this rate is:

Number of terminations in a period

X 100

Number of employees during the period

This rate continues to be a significant measure for determining the success or failure of an organization's retention effort. There is however, a certain amount of ambiguity inherent in this measure; for example, a turnover rate of 100 percent might mean that all positions have turned over once or that a quarter

of the positions turned over four times. No amount of rigor can correct for this ambiguity; other measures must be used in conjunction with the turnover rate in order to clarify the trends. Keeping this in mind, a regional and aggregate summary of turnover rates, for day and residential programs in the selected areas, is presented in Table I.

TABLE I

TURNOVER RATES - DIRECT SERVICE AND SUPERVISING DIRECT SERVICE STAFF

FY'80

	REGION I	REGION V	REGION VI	REGION II (Worcester Area)	AGGREGATE
DAY PROGRAMS	24.2%	45.8%	25%	19.8%	26.4%
RESIDENTIAL PROGRAMS	94.6%	102.4%	60%	86.8%	82.2%

The Stability Rate, which is defined as the percent of the workforce which remains stable for the given time period, is helpful in identifying what portion of the workforce is experiencing the turnover. These rates, computed according to the following formula, are presented in Table 2:

Stability Rate = $\frac{(A+B) - (B-C)}{(A+B)}$, where A = the number of employees in the beginning of the period, B = the number of new hires, and C = total employees at the end of the period - total employees at the beginning of the period.

TABLE 2

STABILITY RATES - DIRECT SERVICE AND SUPERVISING DIRECT SERVICE STAFF

FY'80

	REGION I	REGION V	REGION VI	REGION II	AGGREGATE
DAY PROGRAMS	76.1%	69.4%	82.4%	84.2%	77.8%
RESIDENTIAL PROGRAMS	54.1%	65.3%	62.7%	53.9%	56.9%

8.

Because of the complexity involved in combining the two measures, the following framework should prove helpful:

Low turnover and High Stability = large stable segment turning over slowly.

High turnover and High Stability = high turnover in the unstable segment. (the problem is localized)

Low turnover and Low Stability = large unstable segment turning over slowly.

High turnover and Low Stability = large unstable segment turning over rapidly.

A walk-through of the combined meaning of these two rates makes the trends clearer. For example, in day programs aggregated across the 10 geographic areas, 77.8% of the workforce was stable. Thus, there was turnover in approximately 22% of the workforce, and each unstable position turned over approximately 1.2 times $\left(\frac{\text{Turnover rate } 26.4\%}{\text{Stable workforce } 22.2\%} = 1.2 \right)$.

In residential programs, 43.1% of the workforce was unstable; a turnover rate of 82.2% means that each unstable position turned over approximately 1.9 times $\left(\frac{82.2\%}{43.1\%} \right)$.

The data clearly shows that a significant turnover problem exists for staff in residential programs. One must stop and consider what a turnover rate of 82% must do to an organization and its ability to implement its goals. Remember, also that 82% is only the aggregate figure; one region runs a turnover rate of 102% (although its stability rate is relatively high, suggesting that the turnover is somewhat localized in one segment of the workforce). There are also individual programs running a turnover rate significantly over 100%. Such a level of turnover would be considered unacceptable in the private sector.

Extrapolating from the aggregate numbers of residential programs, it appears that almost one half of the workforce stays for less than six months. For most organizations, six months is considered a minimum probationary or trial period. To have one half of the workforce leaving before the completion of such a period can only imply continual organizational crisis.

The vacancy rates for residential programs substantiate the gravity of the situation. At the beginning of the year, across the pilot areas, the vacancy rate $\left(\frac{\text{number of vacant positions}}{\text{total staff positions}} \times 100 \right)$ was 16.8%. At the end of the fiscal year, the rate was 13.3%. Although some progress has been made in reducing these rates over the year, they remain at a level dysfunctional for any organization and point to the inability of these programs to recruit the necessary staff.

Comparatively, the data for day program staff reflects a less problematic situation. This relative difference in turnover rates for the two types of programs could have been predicted based on the nature of the work involved. It should be mentioned here, however, that the relative "health" of day programs does not imply that their employee movement situation is ideal. Extrapolating once again, almost one fourth of day program employees stay less than 10 months. Considering that the minimum time commitment generally expected from new employees is one year, day programs seem to have their problems as well. Turnover and its programmatic impact persist, despite the fact that day programs provide some career mobility for the system, that employees often come into day programs with MR experience (from residential programs), and that these employees have the expertise that the Department needs to maintain in the system.

























The comparative vacancy rates for day programs at the beginning and end of the year went from 6% to 5.5%. These relatively low rates suggest that day programs can attract people to the available jobs. Another measure, the hiring rate, is a ratio of the number of new hires to the number of applicants for an organization's positions. Although this rate was not available for a number of programs involved in the pilot, the average hiring rate for day programs was approximately 16%. This means that for 100 applicants, 16 people would be hired, a relatively selective rate. The hiring rate for residential programs was approximately 18%. Based on this data, day programs seem to offer more attractive positions to perspective staff than do residential programs.

Salary levels are quite important when it comes to the recruitment of staff. They continue to be an issue when it comes to the retention of staff. A correlation of salary levels and turnover rates was done for direct service staff in residential programs. Programs were grouped into three categories according to their entry level direct service salary: from \$7,001 to \$8,000; from \$8,001 to \$9,000; \$9,001 plus. Programs were also grouped according to their turnover rates for direct service employees: from 0 to 49% turnover; from 50 to 99%; 100% plus. The cross tabulation of programs according to these two variables is presented in Figure 1. The highest turnover is clearly occurring in programs offering the lowest salaries, and the lowest turnover exists in programs offering the highest salaries.

FIGURE 1

TURNOVER TO SALARY CROSTAB:

DIRECT SERVICE STAFF IN RESIDENTIAL PROGRAMS

		DIRECT SERVICE TURNOVER RATES		
		0 - 49%	50% - 99%	100% +
AVERAGE DIRECT SERVICE SALARY	\$7,001 - \$8,000		    	   
	\$8,001 - \$9,000	  	      	 
	\$9,000 +	  		

 = 1 residential vendor

COMMUNITY PROGRAM INTERVIEWS

In order to better understand the issues affecting recruitment and retention in community programs, the Community Personnel Study utilized in-depth interviews with staff at all levels of the system in the 10-pilot areas

Methodology

Agencies included in the interview sample ranged from those serving hundreds of clients to those running one or two programs. Program prototypes included cooperative and staffed apartments, community residences, sheltered workshops, day activity and pre-vocational programs. Over 50% of those interviewed were staff members involved in direct client service, both entry level and supervisory. Approximately 15% of the interviews were with "program coordinator" level staff without direct service responsibilities. An equal number of program and agency directors were included. The remainder of the sample included service coordinators, social workers, and area and regional office staff.

The interview sample was selected so as to comprise a representative cross-section of job categories, levels of responsibility, program types, and perspectives. It should be noted that, in general, staff were chosen who had been in the system long enough to have a clear understanding of the issues affecting them, their co-workers, and their programs.

Interviews were conducted on a confidential, 1-1 basis, and covered such areas as:

- salaries and benefits
- staffing patterns and scheduling
- career ladder and professional development
- orientation and training
- supervision and support systems
- location and transportation
- recruitment and selection procedures
- overall job satisfaction
- relationship with DMH, "System" issues

Since this was an initial research effort, a standardized questionnaire was not used, though basic content areas were covered. In this way, issues that were of significance to those being interviewed rather than pre-conceived hypotheses were allowed to emerge and define the results.

Direct Service Issues

As shown in the preceding section of this report, staff turnover is a critical problem in community programs, and vacancy rates indicate that recruitment is also a major concern. Continual turnover alone necessitates continual recruitment. This can be a very expensive process; one vendor cited annual costs of over \$5,000.00 for advertising.

Vendors reported using a variety of techniques (advertising, employment and college placement agencies, newsletters, bulletin boards, word of mouth, area

offices) with different degrees of success. Numbers of applicants per direct service position varied widely (1 or 2 to more than 20); the number of qualified people interviewed was usually less than 5. Positions were routinely vacant for as long as a month, and sometimes for much longer. This had a detrimental and often devastating effect on both service delivery and staff morale.

There was very little coordination among vendors in their recruitment efforts. The service system as it now exists fosters competition rather than cooperation among providers. However, more basic problems relating to the current nature of direct service work in community programs will have to be addressed before even the most organized recruiting system could be effective. Several key areas emerged as being critical to the successful recruitment and retention of qualified direct service staff.

Compensation and Work Scheduling

Interview data was overwhelming in identifying the lack of competitive salary as the single primary obstacle to recruiting qualified staff people. In the face of a competitive labor market for human services staff, vendors are experiencing difficulty in successfully recruiting staff who meet their standards. Often, vendors find the competitive edge presently enjoyed by the state schools (in terms of salary benefits, regular hours and job security) makes the positions which are available in the vendor organizations even less attractive to those individuals willing and able to work with mentally retarded clients.

Vendors, consequently, are often forced to lower their standards in order to fill long vacant staff positions. Even in those situations where the vendors are able to attract qualified staff, the lack of career mobility and professional development opportunities makes it difficult to retain these staff for an acceptable length of time.

Further compounding this situation are the regulatory requirements for program staff qualifications, which place a heavy emphasis upon academic credentials. This results in recruiting efforts being aimed at young, single people with some college education. Even though often highly skilled and motivated, these individuals constitute a generally mobile population, further confounding vendors' efforts to maintain a stable and qualified workforce. Older, more settled individuals faced with more extensive personal and financial responsibilities are not able to consider these positions due to lack of competitive compensation and benefit packages. One area of concern that is becoming increasingly problematic especially in these types of direct service positions, is that of employee liability. Applicants appear to be less willing to accept positions of this nature without the safeguard of adequate liability insurance coverage provided by the agency.

Interview data was again nearly unanimous in focusing upon the lack of equitability of salaries in relation to the responsibilities and numbers of hours generally required. Current staffing patterns generally require that regular staff work overnight shifts in addition to the basic 40 hour work week. This staffing requirement, generally uncompensated, was felt to be a primary cause of staff burnout and turnover. Interview data suggests that some overnight responsibility on the part of residential staff was accepted as part of the job. However, the current situation of excessive overnight responsibility without compensation was not felt to be a fair or reasonable job requirement.

Additionally, most staffing patterns do not allow even a minimum of benefit time-off (holidays, vacations, sick days, etc.) without causing serious disruption to the functioning of the program. Either co-workers are required to work overtime to provide coverage with minimal or no compensation, or they must "make do" with less than adequate staff-client ratios. This results in inevitable decline in the quality of services and further stress on remaining staff.

The very nature of relief work requires that vendors be able to attract individuals with some amount of experience who are able to provide coverage for short periods of time with minimal program disruption. At present, vendors are constrained in their efforts to obtain reliable relief staff by inadequate or non-existent funds.

The relationship between direct service burnout and low salaries, uncompensated overnights, excessive hours, and lack of relief capability has been previously documented in two Massachusetts studies done in Region VI (Bay Cove Human Services Burnout Task Force Proceedings, 1980; Region VI Workgroup on Personnel Issues, 1980). Both groups identified these factors as among the most critical in contributing to staff instability, particularly in residential programs. For a summary of these findings, please refer to Appendix 2.

A related issue was that of inadequate staff-client ratios. Even when fully staffed, many programs did not appear to have sufficient staff to meet the individual needs of all clients. High ratios are particularly important in programs providing services to more physically handicapped or behaviorally involved clients; otherwise, a disproportionate amount of staff time is focused on only a few individuals. There appeared to be no straightforward mechanism by which programs could contractually adjust ratios to serve changing client mixes and increasing client needs. This can only become more problematic in the future, given the increasingly demanding characteristics of clients moving out of the state schools.

The final compensation issue, clearly emerging from interview discussions was the lack of any consistent and timely mechanism for regular salary increases. It is necessary to address this issue in order to maintain the equitability of salary improvements relative to the cost-of-living, and to provide incentives encouraging increased staff longevity. Please refer to Appendix 3 for a complete listing of current staff salaries.

Orientation and Training

Interview data and research literature (Veninga, 1979) emphasize that the first few months of employment are critical in developing staff longevity. The process of integration into the program and the quality of the "coping skills" provided the new employee during this period have a profound impact. Staff at all levels agreed that a reasonable and structured orientation period is an important element in reducing quick turnover and increasing staff stability. However, current budget mechanisms do not allow a period of overlap between incoming and outgoing staff, and recruiting difficulties often create considerable lag time in filling vacancies. The resulting staffing shortages often result in new staff assuming full job responsibilities before they are fully prepared to do so. This situation results in additional turnover, and continues the cycle of staff instability.

Another area of major concern articulated by all levels of staff was training and professional development opportunities. These were identified as key factors in both recruiting and retaining qualified, experienced staff. Those vendors who had been able to implement some sort of on-going staff development or in-service program reported a marked effect of staff morale and job performance.

Identified training needs included clinical training for direct service staff, management training for supervisory and "first-line" management staff (e.g., program coordinators), and training necessary to properly implement new regulatory, monitoring, and documentation systems.

Clinical training in areas such as normalization, teaching techniques, behavior management, counseling, medical issues, and the like is necessary to develop basic competencies for quality service delivery, and to enable staff to cope effectively with increasingly handicapped clients entering the community system. Management training is critical in developing the skills needed by direct service staff in order for them to assume supervisory and administrative responsibilities. In addition, research has documented a clear correlation between the quality of supervision received by an employee and work performance, job satisfaction, and tenure. Basic familiarity with applicable regulations, documentation requirements, and external monitoring processes is essential for effective staff participation in these activities, which have been designed to improve the quality of the over-all service delivery system. Interview data also suggested that direct service workers' perception of their own jobs were enhanced by a better understanding of the overall system design.

In order to take advantage of any training and staff development opportunities, however, staff must be able to schedule in the necessary time during work hours, requiring supplemental coverage, or be compensated for training received on their own time. Interview data revealed that scheduling training time for direct service staff, for all the reasons enumerated in the discussion on relief coverage, is a major obstacle in implementing workable staff training programs.

In conjunction with other efforts to improve employees' mobility within the community service system, these training efforts should be a step to ensuring that staff have the expertise necessary to take advantage of professional growth opportunities. This will contribute in the long run to the development of a stable and experienced workforce in community mental retardation programs.

Administrative Support

Isolation was consistently identified by direct service staff as one of the most debilitating aspects of residential work. Interviews revealed that many house staff felt detached from the program administration, from other program staff (even within the same agency), and from the system in general. Single coverage greatly exacerbated this experience. While appreciating autonomy, many people expressed a strong desire for more hands-on supervision and guidance from the vendor administration, and wanted a clearer delineation of the responsibilities and liabilities involved in their work. Written, up-to-date personnel policies and procedures, including accurate job descriptions, were seen as an essential first step toward this desired level of clarity.

As one staff person said, "One of our biggest problems is the isolation. The staff here has to do everything and is responsible for everything, and much of the time we really are groping in the dark."

In those programs where isolation was not identified as a problem, the most obvious factor contributing to good staff morale was a responsive and supportive vendor administration, familiar with the needs and frustrations of direct service staff. An active and involved vendor board also helped enormously. Open communication channels, access to information, input into decision-making processes, and demonstrated appreciation for a job well done were essential elements in developing and sustaining a stable, reasonably satisfied staff, especially in the face of difficult and often adverse working conditions. Additionally, staff in a number of programs cited the lack of clinical back-up in crisis situations, either from the vendor, the Department or generic services as a serious resource deficiency.

Other Issues

Miscellaneous issues emerged from the interviews as contributing to staff frustration and dissatisfaction, but were neither universally agreed upon nor correlated in any clear way with staff instability. They were, however, potentially problematic and common enough to warrant mention here.

Problems involving community acceptance affected a number of programs. In some cases, community opposition to siting of new programs and subsequent start-up delays resulted in staff turnover prior to programs' opening. In other cases, staff in operational programs experienced isolation or even hostility from the neighborhood. The most pervasive problem involving community integration, however, was the frequent difficulty encountered by staff in assisting clients in gaining access to generic resources: medical, dental, counseling, recreational, transportation, legal, etc.

Client transportation was a particularly troublesome issue for many people. In many areas where public transportation was not available, staff were forced by the circumstances to use their own vehicles to transport clients to appointments or social events. Current reimbursement rates for travel expenses do not reflect current costs; as a result, staff actually were paying for a portion of client transportation costs out of their own pockets. In these situations, staff had not been informed and were concerned about the extent of their liability in the case of an accident.

In a number of instances, staff also incurred expenses involved in meeting clients' identified needs for social experiences in the community (movies, restaurants, concerts, etc.). Though staff only occasionally paid for the clients' expenses, they were required to spend money on themselves for activities that, given their living expenses and salary levels, they could hardly afford and would otherwise not have chosen to participate in.

Quite a few staff expressed frustration with the lack of funds for physical facility renovations, or for replacement of furniture and equipment beyond repair. The impact of the physical work environment on job satisfaction and performance has long been recognized; there is no reason to believe this is different in these programs. Most staff, however were not aware of the legal complexities involved in these issues (e.g., the Anti-aid Amendment), and instead focused their dissatisfaction on their agency administration or the Department of Mental Health.

A final issue that merits some discussion is that of increasing amounts of paperwork being added to the direct service work load. While the majority of staff interviewed expressed agreement with the value of the structure and process of Individual Service Plan (ISP) development, all stressed that compliance with the concomitant documentation requirements, given current staffing levels, was possible only by means of unreasonable overtime or diminished direct service hours. In general, staff were positive about ISP's, but felt that increased staffing capabilities were necessary in order to properly benefit the clients involved.

In summary, the widespread identification of problems with the compensation scheduling, and orientation/training of direct service staff points to the lack of status accorded to direct service positions. It was generally agreed that direct service workers have historically been as devalued as the clients with whom they work, and that a stable and effective community service system cannot be achieved without a reversal of this trend. The system as it stands rewards people for "moving away from clients" and provides few incentives for remaining in direct contact positions. In order to shift this emphasis, both tangible and intangible measures of worth must be attached to direct service positions: adequate compensation, reasonable hours and responsibilities, adequate training and supervision, professional development opportunities, functioning support systems, and access to decision-making processes.

Administrative Issues

In addition to exploring areas of concern to direct care and program staff, the Community Personnel Study also focused upon issues that were raised by vendor administrators, as well as Area Office and Regional Office staff. The purpose of this line of inquiry was to identify problems related to the Department's system and methods of operation which had an impact upon the general personnel situation currently existing in community programs. Although the number of interviews was limited, there was strong agreement on areas of concern in those that were conducted.

There appears to be a general lack of clarity concerning the appropriate roles for staff in both the Area Office and the Regional Office. In addition, there appears to be this same lack of clarity concerning the role of both fiscal and program staff in the Regional and Central Offices. This situation produces communication problems for all parties in the Department system, with the result that "mixed messages" appear to be a not infrequent occurrence.

This issue of communication also has consequences in the area of policy development. Vendors and Area staff expressed interest and concern that communications around policy decisions be improved and that more input from these staff be incorporated into the policy formulation process.

The current nature of the community services network requires that many clients receive services from a variety of agencies. Program staff identified a need for strong coordination from the Department of Mental Health to assist in securing these necessary services. A problematic outcome of this inter-related network of services, however, is the lack of coordination in the monitoring activity of the agencies that are involved. Administrative staff cited a burdensome increase in the number of inspections and the amount of paperwork that has developed. The current process of documenting compliance with these inspections has placed another workload upon day and residential administrative staff.

The rapid growth of community services has also resulted in the implementation of a variety of new systems designed to insure that quality services are delivered to clients. This period of expansion has produced an inevitable feeling of change and instability in staff within the system. Careful coordination and sensitive implementation of new administrative tasks is needed in order to reduce the general systemic instability that results from periods of organizational expansion.

The Regional Office was generally perceived to be well positioned to provide both Area and vendor organizations with technical assistance and resources to address some of the issues identified in the Community Personnel Study. In those Regions where the Staff Development Officer has begun to function, this individual was seen as providing critically needed assistance in the training area.

Both vendor and Area Office staff indicated both a need and a willingness to work with an individual at the Regional level who would provide assistance in recruiting staff to fill vacant positions and coordinating other personnel issues. This individual was seen as providing technical expertise to assist vendors in combating recruitment and retention problems.

Because the Area Office is the key interface between the vendors and the Department system, considerable effort was made in the Community Personnel Study to focus upon Area Office issues and concerns. The most important issues that emerged from these interviews concerned the role of the Service Coordinator positions. These positions were overwhelmingly applauded by staff at all levels of the vendor organization. The Service Coordinators appear to be meeting the vendors' need for a liaison function.

Turnover within Service Coordinator positions, however, has been problematic since their introduction. Salary levels often were not felt to be equitable to the level of responsibility vested in these individuals. In addition, the pressure of developing and coordinating services for a large number of clients was seen to be a primary cause of staff burnout in these positions. As a result of this turnover vendors experienced some difficulty with the continuity of both services and the systems used by individual Service Coordinators. Because of their critical importance, there was general agreement that the number of these positions be increased in order to reduce the work load to manageable proportions, thereby eliminating a major cause of turnover.

COMPARATIVE SURVEY: MASSACHUSETTS NON-DMH ("PRIVATE SECTOR") VENDORS

The purpose of the private sector study was to explore turnover among human service provider staff employed by agencies which are not DMH/MR vendors. The study was undertaken to provide comparative and supplemental information to findings of the Division of Mental Retardations's community program study.

The objectives of the private sector study were to (1) report average salaries paid to private sector agency staff; (2) explore turnover rates among private vendors; (3) report average hours worked among staff employed by these agencies; (4) summarize recruitment data, and staffing arrangements; and (5) identify other variables that had an impact on turnover among those agencies included in the study.

Methodology

Information was gathered through interviews with direct care, supervisory and administrative staff of private residential programs, schools and day programs for handicapped children, adults and the elderly. The seventy-one programs included in the study ranged in type of program and size from small nursing homes and group residences to large educational and treatment programs serving over two hundred clients. The programs are located throughout the Commonwealth, although a majority of the programs are located in the pilot areas selected for the MR Community Personnel Study. Programs included were those suggested by steering committee members and those chosen at random by the interviewer.

Salary information was aggregated by Region according to type of staff, (e.g. direct care, administrator, etc). Ranges, means, and medians were calculated for each staff category. Data from other salary surveys were utilized to expand the data base for comparative purposes. Massachusetts Public School Teacher's salary levels (as of 9/1/80) were also included.

Turnover rates and average lengths of stay were reported by program directors, summarized, then averaged by position classification. Hours worked represent the evaluation of individuals interviewed for the survey, which were grouped by position classification into categories of 40 hours, 40-50 hours, and over 50 hours.

The information and discussion of the findings of this survey are presented as follows:

First, salary data, average hours worked, and information about fringe benefits are presented.

Second, issues such as recruitment, relief staff, and residence staffing patterns are discussed in the context of staff retention.

Third, training and staff development opportunities are summarized and discussed as a staff turnover factor.

Fourth, management and administrative issues that significantly influence turnover and staff satisfaction are presented and evaluated.

Finally, a comparison is drawn between those agencies with low turnover (<20%) and high turnover (>40%) according to factors such as salary levels, hours worked, inservice training opportunities, and vacation policy.

Salary Data

Salary data on private sector vendors were compiled from both the interview process and from documentation volunteered by participating programs and agencies. In addition, several other sources of salary data were utilized to supplement this study's findings.

The Center for Human Development (CHD) (1981) recently prepared a Salary Study to document the salary ranges for positions in segments of the Massachusetts non-profit human service system. Their study included approximately fifty non-profit agencies, as well as some national and local survey data. To further round out the picture of the competitive job market, public school teachers' salaries were gathered from the Massachusetts Teachers Association. A summary of these compilations appears as Appendix 4.

The salary data in Appendix 4 is grouped according to job function. The categorizations are those used in compiling this study and in most cases, are compatible with staff categories used by CHD. Any significant differences in categorization or job description are noted in the exhibit. Rather than exclude data because it did not fit the format used in this survey, relevant statistics are included for each staff category.
























Certain guidelines are to be used in interpreting the data:


- Data from the private sector study represent averages of beginning salary levels offered by programs to applicants;
- Teacher salaries in non-DMH private vendors have been annualized for a 12 month-year;
- Public School salaries represent yearly amounts paid for an academic year;
- The CHD data are unadjusted for academic or calendar years.

The differences in statistical methodologies and base figures used in compiling this salary data by the various sources make quantitative analysis of this information problematic. In addition, the size of the sample and diversity of program types included make direct comparison between different salary data difficult.

The most illuminating analysis of the salary data is presented in Figure 2. This figure illustrates the relation between salary and turnover levels in residential programs.

FIGURE 2 - TURNOVER TO SALARY CROSSTAB:
CLIENT CARE STAFF (DIRECT CARE) IN RESIDENTIAL PROGRAMS
NON-DMH VENDORS

		CLIENT CARE STAFF TURNOVER RATES		
		0 - 49%	50% - 99%	100% +
AVERAGE SALARY	\$7,001-\$8,000			 
	\$8,001-\$9,000	  	     	
	\$9,000+	      		

 = 1 residential vendor

Certain findings about salaries also emerged through the interview process. Foremost was that low salary levels caused severe problems in recruiting for all staff classifications, especially client care staff. The second central conclusion was that staff, once employed, become discontented about salary when work-load factors lead them to feel overworked and consequently underpaid. The major factor in this dynamic was inadequate relief staff or chronic staff shortages which forced staff to often work in excess of forty hours per week. The most successful agencies with respect to turnover provided for staff shortages and coverage problems by maintaining a readily available cadre of trained relief staff and discouraged overtime hours on the part of regular staff.

Interview data further revealed that administrative, supervisory and direct care staff believed that the disabilities of clients entering their programs were becoming more acute and complex. Interviewees said that because of this phenomenon, all levels of staff were assuming more substantial responsibilities. Most program directors and client care staff noted that salary levels had not kept pace with the increasing job demands.

Hours Worked. Table 3 is a summary of the percentages of staff in major classifications who worked, on the average, 40 hours, 40-50 hours or over 50 hours per week.

TABLE 3





















1. <u>RESIDENTIAL PROGRAMS</u>	<u>40 Hours</u>	<u>40-50 Hours</u>	<u>Over 50 Hours</u>
Direct Service- Client Care Workers	70%	28%	2%
Supervisor or Residence Managers	67%	32%	1%
Teachers & Social Service Practitioners	99%	--	--
2. <u>DAY PROGRAMS</u>			
Direct Service Client Care; Voc. Rehab. Counselors, Aides	89%	10%	1%
Teacher and Social Service Practitioners	97%	2%	--


While most staff in surveyed agencies worked an average of 40 hours per week, those programs where staff often worked in excess of the 40 hours were marked by higher rates of turnover. Figure 3 presents this trend specifically for client care staff in residential programs.

FIGURE 3 - TURNOVER TO HOURS/PER/WEEK CROSSTOAB:

CLIENT CARE STAFF (DIRECT CARE) IN RESIDENTIAL PROGRAMS

NON-DMH VENDORS

		CLIENT CARE STAFF TURNOVER RATES		
		0 - 49%	50% - 99%	100% +
AVERAGE HOURS/PER WEEK	< 40 hours	   		
	40 - 50 hours	   	   	
	> 50 hours	  		  

 = 1 residential vendor

Benefits. Most of the staff interviewed were satisfied with the benefit package offered by their employer. The minimum package offered by agencies included in the study was payment of 50% of the cost of individual coverage in a group master medical plan, six paid holidays (or six additional vacation days) and one week paid vacation after a year's continuous service. The most generous package was a 100% employer contribution toward master medical and dental health insurance, a \$10,000 employer funded life insurance policy, an annuity plan, three weeks of paid vacation during a 10 month year, twelve paid sick days per year, three paid personal days, and two paid professional days a year. Most programs fell in between, with the average including a 50-75% contribution towards a master medical plan, two weeks, paid vacation during the first year, twelve sick days, 10 paid holidays, and two paid personal days. About half of the programs included in the study offered life insurance and annuity programs, and most offered FICA and workman's compensation.

The overall benefit "packages" offered were fairly generous, and did not clearly affect turnover; however, the vacation and leave policies did. The study found that human service staff used comparatively little sick time, but personal days, professional days and vacation periods were critical factors affecting burnout. Programs with the lowest turnover among direct care staff had vacation policies which mandated vacation time on a regular basis throughout the year. Staff cited paid vacation and personal days as factors that increased their effectiveness on the job and their satisfaction with their job.

Recruitment, Relief, and General Staffing Issues

The diverse nature of the sample population did not permit definitive conclusions regarding particular recruitment problems or successes. Interview data, however, was consistent in identifying issues of concern in regards to staff recruitment.

Client care staff were consistently cited as the most difficult to recruit. Interview data were almost unanimous in identifying low starting salary levels as the primary obstacle in attracting qualified client care staff. Programs with a starting salary of at least \$10,000 experienced significantly fewer problems in this respect. Interview data suggested, however, that even salary levels of \$10,000 often did not meet the expectations and requirements of many applicants.

Approximately two-thirds of the programs surveyed did not require formal education beyond high school for these positions. Applicant selection was made on the basis of prior experience and the less precise but admittedly critical factors of "people skills" and ability to work with clients. Many program directors and supervisors stated that prior experience minimized individuals' distorted expectations and helped reduce quick turnover among newly hired staff.

Social service practitioners and special education teachers presented few recruiting problems for programs included in the study. The number of applicants ranged from two or three per slot to over four hundred. Low starting salaries were cited as the reason for few applicants, and program reputation was found to be the primary reason for unusually successful recruiting. Interviews with teaching staff indicated that autonomy was an important reason for choosing a private rather than public setting. The ability to develop and implement their own curricula was found to outweigh the notable salary discrepancies between public and private employment options.

Both interview and turnover data indicated that the availability of experienced relief staff directly affected direct service staff burnout. The availability of relief staff was a major factor in permitting staff to take vacations and planned days off in addition to allowing a program the opportunity to implement inservice training activities. Interview data further revealed that the quality of relief staff was equally as important as its availability.

The lack of relief staff had several important consequences. Incumbent staff often were required to work additional hours to provide coverage for other employees who were out sick. Conversely, some interview data suggests that staff who should be out sick were not doing so because of the increased workload that would fall to other employees in the program. Both of these scenarios produce a situation which increases the likelihood of burnout and turnover.

The staffing arrangements in residential programs included in the study varied almost as widely as the program sample itself did. Interview data, however, did produce concurrence around staffing patterns: Directors and residence staff agreed that incorporating regular periods of time away from the work site alleviated burnout. Insuring that staff have time away from the program requires sufficient numbers of staff and relief staff; interviews and turnover data strongly suggested that programs that planned for and implemented "time-off" for residence staff had higher retention rates among direct service staff.

One-third of the residential programs included in the study employed live-in managers or houseparents, while the remaining two-thirds utilized fixed shift staffing patterns. Turnover data and interviews suggested both advantages and disadvantages to each of these staffing arrangements.

Utilizing fixed shift staffing patterns appears to have a positive impact upon turnover as compared with the live-in model. Although this presented some difficulty in recruiting for the night shift, programs that employed fixed shifts were generally more successful in retaining and recruiting staff. Staff found the convenience of a predictable shift important and relief staff were easier to schedule. In addition, this method of staffing permitted hiring part-time staff for specific shifts when this was a feasible program option. This pattern also reinforced the notion of task completion and "closure".

Programs that rotated shifts or used live-in staff experienced higher turnover than programs using the fixed shift model. Interview data suggests that staff working under these models experience difficulty in separating their personal lives from their professional lives. It appears that the live-in model results in staff neglecting their own lives and produces rapid burnout and turnover.

In addition to the staffing arrangement, several other factors emerged through the interview process that appear to influence staff retention. All of the programs in the study scheduled at least two staff members for each shift or group of clients. This was cited as a critical factor related to burnout as well as quality of client care. Directors and staff acknowledge that this staffing level was necessary to address those common situations where 1:1 work became necessary for a particular client. Virtually all of those interviewed said that this need was an expected, common occurrence, regardless of the severity of disability or age of client. Further, directors indicated that

scheduling at least two staff on every shift was necessary to handle emergency situations, and thus was an operational rule rather than a luxury.

The most successful programs, in terms of staff retention and morale, supplemented all shifts with formal back-up and relief systems. Mechanisms for ensuring back-up coverage varied from assigned and paid beeper duty to a specific listing of available back-up staff members who were paid to be on call. In addition to the obvious emergency benefits of this system, interviewees felt that it gave staff a sense of support and confidence while on the job.

Training and Development

The private sector study revealed that in-service training is one of the most influential factors affecting retention. In addition to developing a more highly trained staff, it was clear that in-service served the broader purpose of communicating an agency's commitment to its staff. Through such training, the professional development of the agency's staff was seen to be important enough to warrant an investment of time and money. With the generally recognized trend of increasingly severe client disabilities, in-service training provided staff with needed additional skills.

Interview data indicated that in-service training activities were an effective means of bolstering staff confidence, and providing a sense of being supported by the program or agency. Interview data indicated that this improved staff retention. In addition, program directors stated that in-service training increased staff effectiveness and provided a critical non-monetary supplement to staff salaries.

Implicit in a well developed in-service program is relief staff or other staffing arrangements which permit regular attendance. Programs which offered in-service training but had insufficient coverage to permit attendance experienced turnover problems similar to those with little or no training opportunities. Among the most useful activities that were cited were consistent weekly 1:1 supervision, case conference sessions chaired by a professional staff person, formal sessions on topic areas suggested by staff members, and visits to other programs and agencies that provide similar services, or that are part of the service network included with the program's clients. Consistency in scheduling these activities, frequency of the sessions, and staff input regarding content were often felt to be as important as the sessions themselves.

Over three quarters of the programs provided some in-service for its client care staff. Two thirds of the programs offered at least weekly formal group supervision and 1:1 individual supervision. Those programs which supplemented these activities with regularly scheduled didactic sessions during paid work time had the lowest turnover rates among this classification of staff.

Table 4 summarizes the number of hours per week scheduled for in-service training activities and percentages of staff who participated (figures rounded):

TABLE 4

IN SERVICE TRAINING

	Five hours per week Plus 1:1 supervision once / week	Up to two hours per week plus 1:1 supervision once/ week	Less than two hours/ week
Senior Administrative Staff	1%	6%	93%
Supervisory Staff	5%	40%	53%
Social Service Practitioners	23%	77%	-
Teachers	13%	88%	-
Residence Managers	10%	79%	9%
Client Care Workers	19%	30%	49%
Teaching Assistant and Aides		11%	88%

Interviews with supervisory direct service workers and analysis of the turnover data revealed that a formal, intensive initial in-service program improved retention. Agencies with the lowest turnover utilized a 6-8 week didactic practicum for new client care staff. Those programs with reasonable turnover rates (less than 30 percent) had some sort of formal initial in-service and usually included a 1:1 "buddy" system" for the first few months. The primary benefits of instituting a formal initial in-service program were seen to be: (1) instituting and contributing to a sense of professionalism among client care workers; (2) building in staff support during the initial weeks of employment which ameliorated much of the stress and anxiety associated with the new position; and (3) supplying new staff with minimum skills needed to successfully perform the job.

Programs that did not provide new staff members with an initial in-service program tended to have higher turnover rates.

A striking consensus to emerge from the interviews among all levels of staff was that career development opportunities in the human services are more limited than in other employment areas. The reasons given for this included: (1) the trend towards smaller community based programs results in fewer positions in program hierarchies; and (2) supervisory and management positions generally include formal educational requirements in addition to training and experience. Increasing regulation and third party reimbursement requirements for postgraduate education and/or certification for clinical direct service staff are seen as contributing to the lack of upward mobility for non-credentialed direct care staff.

Interview data, however, was mixed as to the seriousness of this problem. There was agreement that lack of career mobility within the system was one of the reasons qualified staff left the program after a year or so of direct service work. Staff are often hired with the understanding that, after some requisite direct service experience, these staff intend to qualify for a clinical or supervisory position or leave the program.

The primary source of career development is the progression from direct service to a supervisory position. This is particularly true in residential programs. The transition from direct care to management, however, is not an easy one. This progression can have a significant effect upon the morale of an agency staff. There is, consequently, a critical need to provide the new supervisor with training in managing and supervising. Useful content areas were felt to be: organizational behavior, analytic techniques, regulations, and administrative procedures. Clinicians, in particular, found the transition frustrating. Successful programs in this regard reflected management which had carefully planned for this transition and had incorporated supervisory training.

Human Resource Management

Organizational Behavior literature (March and Simon, 1958) indicates that staff input into the decision making process has a beneficial influence upon staff members' commitment to the organization. Applying this concept in human service programs requires attention to procedure rather than substantive restructuring or financial commitments. Including staff in client program decisions appears to have a bearing upon the turnover experienced by programs in this survey.

Programs that experienced low turnover among direct care staff indicated that including these staff in case conferences was an agency policy and enhanced their ability to retain staff. The opposite situation was found among those programs that experienced chronically low staff morale and high turnover. Consistently, other service providers who worked with clients on an infrequent basis had sole input into treatment plans. Programs successful in retaining client care staff included case conference time in their workers' schedules, and ensured that their views were elicited and included in the client's treatment and habilitation program.

Communication within the program or agency was found to be an important factor in staff morale and job satisfaction. Staff committees, formed to address specific agency issues, contributed to higher staff morale and improved interagency communication. Regardless of the size of the agency, regular staff input into decisions and programs produced lower turnover, and interview data supported this kind of two-way communication as a significant factor. Further, the interviews revealed that staff meetings and team collaboration provide important mutual staff support.

A common theme among all programs was that the degree of concern and distance perceived by the staff vis-a-vis the agency's upper management affected morale and retention. Among programs with the lowest turnover, staff indicated that the administration was visible and genuinely accessible. Many staff members cited this as a reason for their commitment to the program.

A second theme to emerge from the interviews was the importance of real and perceived support and interest exhibited by the Board of Directors. Directors of programs that were able to retain direct care staff voluntarily cited a supportive, energetic Board of Directors as one of the reasons for their success. They indicated that this relationship was enhanced by frequent contact through regularly scheduled meetings.

Among those programs included in the study were several that experienced high turnover among direct care staff, supervisory and administrative staff. Without fail, among the reasons cited for these severe staffing problems was the director's and staff member's sense that: (1) the Board was incompetent as a governing agency; (2) the Board was disinterested in the program or agency and its operations; or (3) the Board made decisions about the agency without input from the program's administration or staff members.

Three of the programs included in the study were in jeopardy of discontinuing operations because of insufficient resources, inability to meet licensing requirements, and concomitant problems associated with instability and financial turmoil. The obvious effect on staff morale and retention proved true - turnover was very high. Those staff who remained were seeking other employment, or were staying only out of concern for clients and planned to leave within the foreseeable future.

Staff of those programs which were the most stable - well accepted and supported by the community, well managed financially and sanguine about future stability - cited this as a reason for successful recruitment efforts and practically zero vacancy rates.

One focus of the comparative Massachusetts "private sector" survey was to identify the significant differences which exist in programs experiencing the different levels of turnover. Appendix 5 presents a composite picture of salient factors in each of three turnover categories. As can be seen from the exhibit, the position of the agencies in regards to the issues raised in this report substantially correlate with the rate of turnover experienced.

Interview data and observations from the private sector study indicates that effective staffing in human service programs requires that attention be given to human resource management. There must be adequate funding to enable programs to offer reasonable salaries to direct care staff. There must be enough staff members in an agency or available to the agency to permit staff to work forty-hour weeks, participate in inservice training activities and take vacation and regular days off. Attention must be given to needs of staff for support, self esteem and self actualization, and resources must be directed to formal inservice training and development activities.

COMPARATIVE STUDY: NATIONAL SURVEY

In order to provide a context within which to evaluate the findings of the Community Personnel Study, a national survey was conducted. The purpose of the survey was to identify staff recruitment and retention-issues in community based programs in other states. A second objective was to develop a data base around such variables as salaries, benefits, training, and work schedules.

Methodology

Several different approaches were used to identify and collect relevant data from other states. Letters requesting study data of recruitment and retention in community based MR/DD programs were sent to over 30 individuals throughout the country. These individuals are prominent in personnel related research and include both state and Federal agencies and the academic community. Each letter was followed by a telephone call to confirm the request. In some cases, interviews were conducted which often produced additional referrals.

A literature search was also conducted. This included contact with information sharing organizations for human service agencies. Several unpublished monographs were secured via this process.

Finally, staff from the Division of Mental Retardation conducted telephone interviews with executive and middle management staff in programs identified by state Mental Health or Developmental Disabilities agencies. These interviews were structured similarly to those utilized in other segments of the Community Personnel study.

Findings

The results of the different research methods are presented below according to the variables of salary, benefits, training, and work schedules. In the final analysis, the results of the national survey are disappointing. Data on turnover in community based programs was almost non-existent, and hard data on salaries and benefits was scarce. Despite the national trend to community services, and the enormous collective budget of the states devoted to personnel in these programs, very little attention has been devoted to identifying and resolving relevant issues. Effort in this area by the Commonwealth of Massachusetts appears to be a "ground-breaking" venture.

Salary

Despite the various contacts with other states, this survey did not produce meaningful information concerning salary ranges offered to staff of community programs. The best source of this data, consequently, is a 1979 study done by the Child Welfare League of America (CWLA, 1979). This survey encompasses 190 agencies throughout the country and includes over 3500 residential positions.

Table 5 presents information drawn from the Child Welfare League survey and a health care services study done by the state of Colorado (Foote, 1980). The range of salaries compiled as part of the Division of Mental Retardation's study of Massachusetts are included for comparison.

TABLE 5
COMPARATIVE SALARY RANGES

<u>Position</u>	<u>Salary Range</u>
Residential Supervisor	\$13,000 to \$14,000
Upper 25%	\$16,000 to \$17,500
Mental Health Workers	\$10,500 to \$14,256
Psychiatric Technicians	\$10,450 to \$13,760
MR Technicians	\$ 9,460 to \$12,675
Residence Worker (Massachusetts 1980)	\$ 5,750 to \$14, 080
Residential Supervisor (Massachusetts 1980)	\$ 7,580 to \$17,100

Benefits

There is increasing evidence in the literature and in surveys of industrial workers that benefits are perceived to be a significant component of the overall compensation package. A longitudinal survey conducted by the University of Wisconsin at Madison (Heneman, Schwab, Fossum and Dyer, 1980) shows a marked change in employee preference towards increased benefits during the period 1959-1974. Increased benefits were preferred to increased pay in this survey.

Three reasons appear to contribute most significantly to this trend. The first is that employees can purchase benefits such as health and life insurance for less cost through the employer's group plans. Second, the progressive tax structure of federal and state tax laws makes it beneficial for employees to receive compensation through non-taxable benefit provisions rather than through increased pay. Third, government policies designed to protect employees against the uncertainties of employment (accidents, unemployment, retirement, illness) have contributed to the growth of benefit provisions.

Current estimates are that voluntary and mandatory benefits now average over 30% of total compensation (Heneman, Schwab, Fossum and Dyer, 1980). This compares to approximately 18% of total compensation in 1957. Time not worked - vacations and days off - is the largest portion of benefit expenditures.

While this survey did not attempt to compare directly the benefits offered to workers in community programs with industry averages, the data in Table 6 indicates that benefits to community workers have lagged far behind other sectors of the economy.

TABLE 6
FRINGE BENEFIT PROVISIONS
SAMPLE OF VENDOR AGENCIES

	% Fringe	*Employer Subsidised Health Plan	Vacation Time
CALIFORNIA	13-15%	Yes	Yes
MAINE	16%	Yes	Yes
MICHIGAN	No Fringe	No	No
NEW HAMPSHIRE	15-16%	Yes	Yes
NEW JERSEY	No Fringe	No	No
OHIO	11-13%	No	Yes
PENNSYLVANIA	15-17%	Yes	Yes
TEXAS	14-16%	Yes	Yes
VIRGINIA	12-15%	Yes	Yes

While hard data was difficult to gather in the area of benefits, the survey done by the state of Colorado does shed some light on the benefits generally provided to health care employees. Results of the Colorado survey indicate:

- 93.4% of survey respondents indicate that they consider both pay and benefits to be integral components of an employee compensation package;
- 40.2% indicate that the fringe benefit package is adjusted yearly;
- 78.3% indicate that employees may accrue 12 or more sick days per year with full compensation;
- 83.7% indicate that basic hospitalization, surgical and/or comprehensive medical insurance is provided to employees;
- 79.4% indicate that they pay either the full or a major share of the cost of life insurance for employees;
- 96.6% indicate that they have a pension plan for employees other than social security.

It is important to note that this survey concerned state and hospital benefit provisions and did not include community program agencies. The survey does highlight the extent to which benefits to community workers have lagged behind the norm of other health care organizations.

Training

A review of the literature clearly demonstrates that staff training is increasingly perceived as an important organizational component which addresses

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employee needs in the areas of skill development, career progression, and morale building (Porter and Steers, 1978). This view of staff training also emerged from interviews conducted in the several states. A solid orientation program and regular training opportunities were seen as an essential "lynch-pin" in the organization's efforts to build a qualified and stable work-force.

As was the case with benefit provisions, in the area of training community programs also lag far behind the "state of the art" being practiced by most organizations. Despite solid evidence indicating the range of benefits enjoyed by the organization as a result of training initiatives, community programs are either unable or unwilling to offer training opportunities. Table 7 presents survey information.

TABLE 7

TRAINING PROGRAMSSAMPLE OF VENDOR AGENCIES

	<u>M A N A G E M E N T</u>		<u>C L I N I C A L</u>	
	<u>Training Offered</u>	<u>Time Compensated</u>	<u>Training Offered</u>	<u>Time Compensated</u>
PENSSYLVANIA	Yes	Yes	Yes	Yes
NEW HAMPSHIRE	No	No	No	No
CALIFORNIA	No	No	No	No
MAINE	Yes	No	Yes	No
MICHIGAN	Yes	Yes	Yes	Yes
VIRGINIA	No	No	Yes	No
NEW JERSEY	No	No	Yes	Yes
TEXAS	No	No	No	No

Work Schedules

The final area surveyed as part of the national study concerned work schedules for community program staff. As with other areas of inquiry, hard data was difficult to find. While considerable data exists for industrial organizations, little information has been gathered in the mental health care field.

The Compensation Study and Occupational Review done by the state of Colorado did produce some data around work schedules. The survey found:

- 92.2% of the responding organizations indicated that their normal work week schedule involves 5 days and 40 hours or less;
- 96% of the respondents indicated that they pay time-and-a-half for hours worked after either an eight hour day or forty hour week;

- 68.5% of the respondents indicated that their employees are paid for the inconvenience of being "on-call."

Interview data from the several states indicates that work schedules for community workers often exceeds 40 hours and that compensation for this time is generally not provided. As with the other areas reviewed in this report, the situation that currently exists in community programs is strikingly sub standard in comparison to most organizations.

SUMMARY AND CONCLUSION

33.

In community-based mental retardation programs in Massachusetts, the statewide turnover rate for day programs is 26%, and for residential programs, 82%. Stability rates statewide are 78% and 57% respectively. This data documents a very critical situation in residential programs, and one that is far from ideal in day programs.

Analysis of the information presented in the various components of this study clearly identify the most salient factors involved in recruitment difficulties and turnover:

1. Inadequate salaries and lack of systematic mechanisms for pay adjustments.
2. Non-competitive and incomplete benefit packages.
3. Excessive work hours, unpredictable work schedules, and inadequate compensation for overtime work.
4. Insufficient relief capability, especially as it affects a) overtime requirements, b) staff participation in training programs, c) ability of staff to take benefit time off and d) staff-client ratios.
5. Low staff/client ratios.
6. Inadequate initial and continuing in-service training opportunities, and staff supervision.
7. Lack of viable career development opportunities.
8. Absence of effective communication and support systems, and resultant staff isolation.
9. Lack of cooperation, coordination, and leadership at all levels of the service system.

It is critical to note that the residential and day programs surveyed in the DMH community system draw from the same general labor pool and serve identical groups of clients; salaries are uniformly low, and the training situation is similar. Yet there is a 56% higher rate of turnover in residential programs. Based on the data, the primary differentiating factor is work schedules. Because of 365 day/year, overnight staffing requirements most residential staff routinely work well in excess of 40 hours per week without additional compensation. Burnout is swift and predictable. In order to reduce turnover in these programs to acceptable levels, it is imperative that adequate fiscal resources be directed toward normalizing the residential work week. Funding for overnight and relief staff is vital to the capability of these programs to provide consistent, quality services. Salary increases alone, while a necessary first step, will not be sufficient to retain staff forced to deny many of their own needs in order to ensure the provision of services.

To effectively deliver services within the complex system that presently exists, it is essential that all parties address the issues raised in this report in a businesslike manner. The partnership that exists between the Department of Mental Health and the provider organizations must be recognized and integrated into daily and long term operations. Only through full cooperation among all concerned can the potential intrinsic to the community services concept be realized.

The personnel needs of the community service system are great. Its basic foundations must be strengthened. This requires that the job needed to perform these services be attractive and valued in order to encourage quality personnel to work and stay within the system. As long as the current situation remains, the community program system will continue to exist in a state of crisis.

RECOMMENDATIONS

The Community Personnel Study has identified a variety of issues which contribute to the troublesome recruitment and retention problems quantified and discussed in this report. Some of these problems are the result of low salaries, excessive workload and training deficiencies. Other problems are the result of a rapidly expanding system and the need for greater attention to be devoted to managing the human resource component. As noted by Dr. Robert Okin, in his memorandum of December 22, 1980, announcing Project: CARE: "Inadequate attention has been paid to our ability to properly manage our now more complicated service system."

Because the principal resource for the delivery of quality services to clients is the staff of the provider organizations and the staff of the DMH system, it is fundamental that human resource issues be addressed as a priority task. This requires the attention of top management, the application of resources sufficient to accomplish the tasks that are recommended, and a commitment by the organization to address and resolve a host of complex and inter-related problems.

The recommendations which follow are presented in the form of discrete and concrete tasks. This approach allows for the identification and resolution of specific problem areas. It is hoped that this approach will help avoid problems inherent in undertaking such a complex task as "personnel management." It is fundamental, however, to view these task recommendations as components of an overall program designed to improve the ability of the system to attract and retain qualified staff. This program should address salary and related compensation issues as well as processes and procedures needed to maximize the effectiveness of personnel operations.

Recommendations to address issues identified in this report therefore, are presented in two clusters. The first cluster concerns present personnel operations and is designed to share information and to identify and build a working network of individuals who will focus upon and help resolve personnel operations problems.. The second cluster concerns the resolution of problems such as salary levels, relief staff availability, excessive work loads, and training deficiencies. This second cluster was presented in the Executive Summary of this report in November, 1980.

In order to establish priorities in resolving some of the personnel related operational problems within the Mental Retardation Community Program system, an organized and directed effort must be made to separate fact from fiction in a variety of areas. This effort requires leadership, accountability, and input from all concerned parties. This study recommends that a Community Personnel Task Force be established and charged with the responsibility to identify problem areas and develop recommendations to resolve the problem. This Task Force should contain a statewide Steering Committee, and several sub-committees charged with task-specific projects. Figure 4 presents a schematic diagram with the recommended organizational structure and the recommended minimum membership of the Task Force.

The Community Personnel Task Force would provide the operational mechanism for improved, consistent communication within the MR Community system around the issues of training and personnel. The Task Force should be provided the opportunity to develop a detailed agenda, but at a minimum should address the following issues:

recruitment strategies and procedures, personnel processing obstacles, career mobility, and personnel data collection. The Task Force should oversee and review the recommendations of the several sub-committees and present recommendations and implementation plans to the Assistant Commissioner, Division of Mental Retardation. After an appropriate period of time, the Community Personnel Task Force should merge with the State School Personnel Task Force to form a single committee on personnel matters.

The several sub-committees reflected in Figure 4 and noted above constitute discreet working groups which should disband at the conclusion of the assigned task. The recommended tasks for the 5 sub-committees noted in Figure 4 are:

- Policy Input: to establish a procedure for formal input to policy formulation and review around training and personnel matters;
- Early Intervention/Specialized Home Care/Respite Care: to coordinate and assist in the implementation of recommendations resulting from personnel surveys in these areas;
- Training: to address training issues of scheduling, notification and delivery coordination; to develop procedures for accessing various staff development opportunities (i.e. procedures on staff released time, tuition reimbursement); to identify methods of improving access to current staff development opportunities for all DMH and vendor staff; to develop improved methods of utilizing existing staff development resources such as Red Cross, Local Adult education programs and higher education programs;
- Community Acceptance: to review needs and steps to be taken to improve community acceptance, particularly as it affects staff stability and recruitment;
- Communication: to review existing processes for communications and develop needed mechanisms to insure the timely flow of accurate information from the Dept. of Mental Health to vendor organizations in the areas of training and policy development.

In addition to establishing the Community Personnel Task Force, this study recommends that the Division of Mental Retardation convene a series of regional meetings with the express purpose of disseminating the information compiled in this report and exploring ways that this information can be used as a management tool. These meetings should include Regional Personnel Directors, Regional Training Coordinators, and representatives from the major vendor organization in the Region.

Many providers commented upon the burden placed upon staff by the multiple inspection and certifications required by different state agencies and by different functional units in the Department of Mental Health. Because the stress and work load factor brought about by this situation appears to impact upon turnover, this study recommends:

- efforts be made within the Department of Mental Health to coordinate and consolidate some of these monitoring activities;
- the Division of Mental Retardation should pursue establishing inter-agency agreements with the Massachusetts Rehabilitation Commission to reduce the number of duplicitous certifications; this should involve identifying those inspections which are required by law and those which are a matter of agency policy;
- at a minimum, efforts should be made to coordinate inspection scheduling at the Regional level.

Other Recommendations in this cluster are as follows:

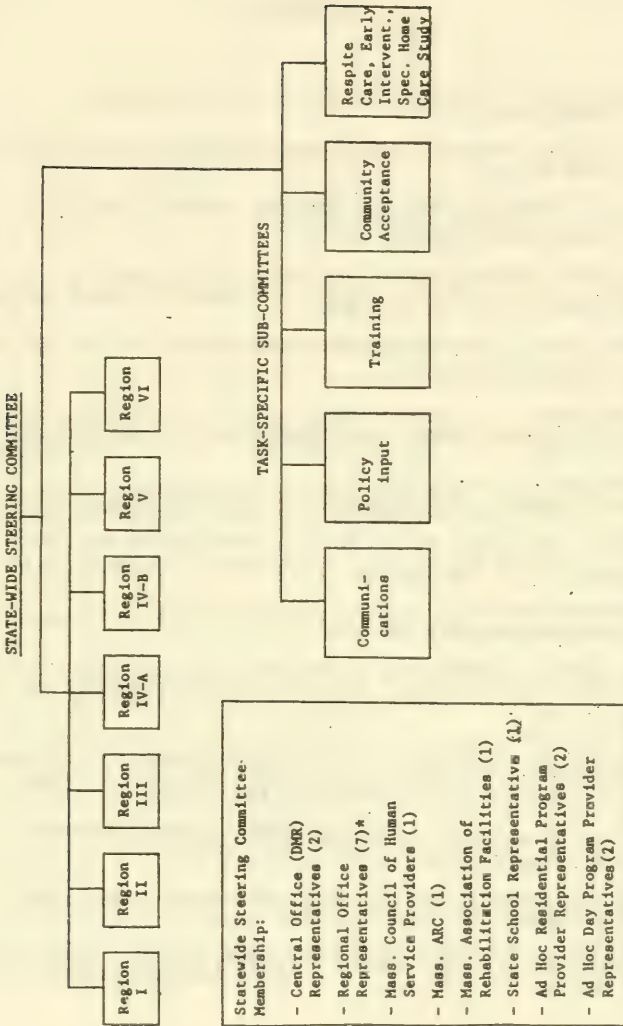
- a. The Division of Mental Retardation should continue to support and work closely with staff in Region IV-B on establishing a Regional Training Institute as a prototype which may be applicable in other parts of the state.
- b. The Division of Mental Retardation should continue to pursue the interests in Regions I and IV-B in establishing a Regional recruiting function.

The Executive Summary of this report presented a series of recommendations to address the issues concerning low salaries, lack of relief staff, training deficiencies, and fringe benefits that have been identified as contributing significantly to staff turnover. These recommendations are presented again in order to emphasize the critical nature of responding to the financial difficulties.

1. A minimum salary range for direct service staff of \$10,500 - 11,500 should be established.
2. A minimum salary range for senior supervising direct service staff of \$12,00 - 13,500 should be established.
3. A minimum salary range for first line management staff of \$14,000 - 15,500 should be established.
4. A minimum fringe benefit level of 15% of the total base personnel costs should be established.
5. Vendors' requests for funding for liability insurance coverage should be honored.
6. Compensation for currently documented unpaid overnight sleep-in coverage should be provided at minimum wage level. This will allow vendors to either compensate present staff for these unpaid hours, or reduce the workload by hiring additional sleep-in staff.
7. Funding should be provided to allow vendors to secure adequate relief coverage for benefit time-off (holidays, vacations, sick days) for regular staff. This funding should be provided at the competitive rate of \$5.00 per hour.

8. Funding should be provided to allow vendors to either secure adequate relief coverage for staff attending required in-service training, or to compensate staff for attending such training during time beyond their normally scheduled work hours. This funding should also be provided at the competitive rate of \$5.00 per hour.
9. The position of Regional Personnel Officer should be established in each of the 7 regions of the Department of Mental Health. This position will be responsible for developing and coordinating effective strategies for attracting and retaining qualified staff, and providing technical assistance in implementing these strategies to vendor organizations.
10. The Division of Mental Retardation's. State and Regional Staff Development Plans should be implemented as fully as possible in FY 1982.
11. Further study should be done regarding the adequacy of levels of supervision in existing community programs. Staffing levels in these programs should be comparable to those called for in the Cost Models used for the development of new programs. Initial adequacy recommendations based on this data should be implemented no later than FY 1983, and subsequently as necessary.
12. To ensure the development of a stable workforce across all mental retardation service models, a further study should be conducted incorporating the models of Specialized Home Care, In-Home and Out-of-Home Respite Services, and Early Intervention. Fiscal recommendations resulting from this research should be implemented no later than FY 1983.
13. To ensure the stability of all levels of staff in the community service system, further data should be collected regarding specialist/ professional staff, senior administrators, and other support staff (clerical, maintenance, etc). Fiscal recommendations resulting from this research should be implemented no later than FY 1983.
14. The Budget Bureau should review the process of establishing cost of living funding adjustments for community programs salaries and strive for a timely and adequate determination procedure.

FIGURE 4
COMMUNITY PERSONNEL TASK FORCE



*This individual should be able to address issues of personnel, training, and info.

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APPENDICES

APPENDIX 1
SAMPLING STATISTICS

TABLE (1)

Area	Population (2)	Density (3)	Unemployment (4)	Per Capita Income (5)
			%	\$
<u>Region I</u>				
*Berkshire	148,684	157.8	6.11 %	\$ 5,261.69
*Franklin-Hampshire	147,027	156	5.08	5,076.22
*Holyoke-Chicopee	187,156	577.6	5.69	5,038.2
Springfield	209,181	2,134.5	4.3	6,642
Westfield	97,750	280.9	7.39	5,367.45
Average (6)	149,392	392.2	5.73 %	\$ 5,252.85
<u>Region II</u>				
Fitchburg	155,224	442.2	6.19 %	\$ 5,385.53
Gardner	77,447	107.7	6.11	5,131.63
Blackstone Valley	137,555	469.5	8.43	5,162.2
So. Central	92,104	253	5.6	5,016.06
*Worcester	242,111	1,301.7	4.45	6,115.87
Average (6)	127,522	393.3	6.44 %	\$ 5,276.09
<u>Region III</u>				
Lowell	231,157	1,351.8	6.7 %	\$ 5,361.37
Lawrence	146,877	1,631.9	6.3	6,051.5
Haverhill/Newburyport	112,237	593.8	5.9	6,032.36
Cape Ann	108,986	778.5	5.4	6,858.33
Danvers/Salem	137,487	2,370.5	4.6	6,408.8
Lynn	139,458	3,769.1	5.2	7,100
E. Middlesex	115,779	2,692.5	4.6	6,359.8
Tri-City	156,777	8,709.8	5.6	5,499.66
Average (6)	141,723	2,026.4	5.3 %	\$ 6,220.4
<u>Region IVA</u>				
Concord	83,226	590.3	3.6 %	\$ 6,421.06
Mystic Valley	186,316	2,624.2	4.5	6,857.5
Met. Beaverbrook	124,102	5,641	4.5	8,897.33
Cambridge-Somerville	175,752	15,977.4	6.2	5,860.5
Average (6)	129,625	3,497	4.27 %	\$ 6,567
<u>Region IVB</u>				
Marlboro/Westboro	81,141	901.6	3.54 %	\$ 6,163.4
Greater Framingham	165,938	953.7	4.06	7,811.55
Newton Wellesley	159,191	2,698.2	3.63	10,071.25
Medfield/Norwood	173,214	946.5	3.93	6,503.92
So. Shore West	146,033	3,107.1	4.47	6,714
So. Shore East	159,189	1,501.8	4.46	6,731.29
Average (6)	154,172	1,660.9	4.01 %	\$ 7,167.87
<u>Region V</u>				
*Attleboro	85,505	784.5	5.7 %	\$ 5,384.5
Brockton	224,340	1,393.4	6.2	5,285.0
*Plymouth	108,135	558.1	6.9	5,471.7
*Taunton	97,915	545.9	6.9	5,407.7
Fall River	148,984	925.4	8	5,019.4
New Bedford	172,649	744.2	6.7	5,246.1
Cape Cod	138,225	246.8	7.5	5,680.9
Average (6)	146,365	713.81	7.04 %	\$ 5,433.9

APPENDIX I (Cont'd.)

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Region VI

Because comparable data by cities and town was not available for the areas in Region VI as they were in the other six regions in Massachusetts, data were extrapolated using Suffolk County information, demographic statistics published by the Census Bureau for the Cities of Boston and Brookline, and data published by the Department of Mental Health - DMH Regional /Area Composition effective 7/1/78.

<u>Population</u>		<u>Per Capita Income</u>	<u>Unemployment Rates</u>	
Suffolk County	= 735,190	5120	Boston	6.4
Boston	= 641,074	5088	Brookline	3.7
Chelsea	= 30,625	4741	Revere	7.2
Revere	= 3,159	5405	(average) x =	5.76
Winthrop	= 20,335	5938	Square Miles, approximation of	
(average) x	= 5258.4		Boston SMSA =	53;

Density: Sample Areas vs. All DMH Areas

<u>Number of Areas</u>				<u>Population in Each Group</u>			
<u>Sample</u>	<u>% of Total</u>	<u>All Areas</u>	<u>% of Total</u>	<u>Sample</u>	<u>% of Total</u>	<u>All Areas</u>	<u>% of Total</u>
<u>Density less than 500</u>							
2	20%	8	19.5%	295,711	11.9%	896,266	15.6%
<u>Density 500-200</u>							
5	50%	20	48.7%	720,822	48%	2,486,213	42.3%
<u>Density Greater than 2000</u>							
3	30%	13	31.7%	457,634	31%	2,426,890	42.1%
10		41		1,474,167		5,759,369	

Percentage of total population included in sample: 25.6%

Notes

1. Population, Unemployment and Per Capita Income Statistics were aggregated by areas, using town and city statistics referenced below.
2. Population are 1970 figures published in Current Population Reports, Series P-25, No. 882, dated June, 1980 published by the U.S. Bureau of the Census.
3. Density is population of all cities and towns in each area divided by Square Mile per area; the latter furnished by the Office of State Planning.
4. Unemployment rates are May, 1980 preliminary estimates published in Labor Area Research Publication, Volume 4, Number 5, May, 1980 by the Massachusetts Division of Employment Security.
5. Per Capita Income figures are 1977 estimates published by Current Population Reports.
6. Averages are weighed averages based on number of towns and cities in each area.

APPENDIX 2

Region VI Studies

The issues that emerged from the Community Personnel Study as critically affecting staff stability are substantiated by the findings of two Work Groups in Region VI (Greater Boston) - the Bay Cove Human Services Burnout Task Force (1980), and a direct service work group regarding personnel issues in the region (1980).

1. The Bay Cove Task Force was composed of representatives from all program areas within the agency (mental health, mental retardation, day, and residential). In a series of eight meetings, they identified and discussed the issues considered most crucial to the high turnover rates experienced in the area. These problem areas, which "coincided with all the reasons former direct care staff gave for terminating, were as follows:

1. Hours, including such issues as irregular schedules, emergency coverage demands, working overnights,* and the inability to fit required work (including meetings, training, etc.) into a 40-hour week.
2. Pay, including such issues as inadequate salaries, no mechanisms for pay increases, lack of equity between contract and DMH employees, and uncompensated overnights*.
3. Lack of Staff, including such issues as isolation, lack of safety and programming capabilities caused by single coverage, inadequate emergency back-up, and difficulty taking breaks or compensatory time off.
4. Inadequate/Ineffective Relief Staffing, including such issues as inexperienced and untrained relief; lack of relief for training time, emergencies, overnights, sick days, compensatory time, etc.; and difficulty recruiting regular relief staff.
5. Training and Orientation, including such issues as inadequate orientation; need for periodic training and workshops, career counseling, management training, and a career ladder; and lack of educational benefits.
6. Unrealistic Expectations, including such issues as unrealistic expectations of clients, unrealistic demands put on staff, need for cross-training between residential and day programs, overinvolvement, and inappropriate job titles.
7. Inadequate Program and Client Resources, including such issues as inadequate SSI income for clients, inadequate funding to provide for staff compensation (additional staff, overnights, raises, etc.) and poor condition of program space.

* "Residential staff concluded that the most critical (staffing) difficulties for them were not sleeping well when working overnights and not receiving compensation for them".

APPENDIX 2 (Cont'd.)

II. The direct service work group distributed a questionnaire to staff in residential programs across the region. Data was gathered regarding the issues identified by the group as "most pressing and widespread". In addition to inadequate salaries, these were overnights, overtime, and relief. The findings included the following:

1. Overnights

- a. 88% of the respondents were required to do overnights.
- b. 62% had no overnight staff in their program.
- c. Of those required to work overnights, 89% had them scheduled above a 40-hour week.
- d. 69% received no compensation for overnights, and only 15% were actually paid.
- e. 75% of all respondents were dissatisfied with the overnight situation; of those required to do overnights, 84% were dissatisfied.

2. Overtime

- a. Only 43% of the respondents received some form of pay for overtime (21% after 45 hours).
- b. Of those receiving overtime pay, 53% received regular wage, 28% received time-and-one-half; no one received double time; 19% received "other".
- c. For those not receiving overtime pay, 44% were not compensated at all, and 56% were offered (but were unable to take) compensatory time off.

3. Relief

- a. During staff or client vacations, 39% of staff were not provided with relief coverage.
- b. For staff training activities, 57% were not provided with coverage; 10% were provided this coverage only "sometimes".
- c. In order to take compensatory time off, 50% were not provided coverage; 16% only "sometimes".
- d. During staff illness, 39% were not provided coverage; 18% only "sometimes".
- e. During client illness, 41% were not provided coverage; 20% only "sometimes".
- f. During client emergencies, 48% were not provided coverage; 24% only "sometimes".

APPENDIX 3

Massachusetts:
Average Salaries - Currently Paid

Region	FLM (day)	FLM (res)	FLM (total)	SDS (day)	SDS (res)	DS (day)	DS (res)
I	13,810	14,850	14,220	11,380	10,790	8,900	8,730
II	14,040	14,220	14,160	10,390	11,280	8,430	9,250
III	13,840	14,810	14,500	11,130	11,500	9,620	9,720
IV-A	14,680	13,570	14,210	11,150	11,900	9,920	9,650
IV-B	15,560	15,940	15,880	10,300	11,880	8,640	9,040
V	13,920	13,680	13,810	10,780	11,300	8,530	9,330
VI	14,110	16,020	15,340	12,120	12,120	9,970	9,690
MA.	14,070	14,730	14,440	10,970	11,360	8,920	9,200

FLM: First Line Management

SDS: Supervising Direct Service

DS: Direct Service

day: Day Programs - does not include programs with audited day rates

res: Residential Programs

APPENDIX 3 (Cont'd.)Salary Ranges - Currently Paid

Region	FLM (day)	FLM (res)	FLM (total)	SDS (day)	SDS (res)	DS (day)	DS (res)
I	12,000- 18,180	11,000- 20,000	11,000- 20,000	9,000- 12,940	7,530- 15,000	7,200- 10,600	6,000- 10,750
II	12,900- 16,500	11,600- 17,150	11,600- 17,150	9,370- 12,650	9,370- 12,970	6,360- 10,820	6,840- 11,000
III	12,200- 18,000	11,420- 20,000	12,200- 20,000	9,000- 12,900	10,200- 15,000	7,430- 11,110	7,015- 11,620
IV-A	13,000- 18,000	11,800- 17,200	11,800- 18,000	9,930- 12,500	10,500- 13,400	8,530- 11,740	7,150- 11,300
IV-B	10,300- 17,300	12,500- 21,200	10,300- 21,200	9,000- 13,370	7,790- 17,100	7,800- 12,130	5,750- 14,080
V	11,200- 19,700	10,600- 16,500	10,600- 19,700	9,100- 13,550	9,000- 12,750	5,590- 11,140	6,500- 11,000
VI	12,860- 16,000	12,740- 20,080	12,740- 20,080	10,600- 15,650	9,500- 15,000	7,500- 10,500	6,450- 12,000
MA.	10,300- 19,700	10,600- 21,200	10,300- 21,200	9,000- 15,650	7,530- 17,100	5,590- 12,130	5,750- 14,080

FLM: First Line Management

SDS: Supervising Direct Service

DS: Direct Service

day: Day Programs - does not include programs with audited day rates

res: Residential Programs

APPENDIX 3 (Cont'd.)Number of Full-Time Equivalent Staff Positions Used in Salary Calculations*

Region	FLM (day)	FLM (res)	FLM (total)	SDS (day)	SDS (res)	DS (day)	DS (res)
I	22	21	43	20	97	62	326
II	8	16	24	18	48	31	153
III	7	15	22	11	41	26	125
IV-A	9	9	18	11	23	20	50
IV-B	3	15	18	11	41	25	130
V	19	18	37	31	25	95	153
VI	6	12	18	10	29	22	126
MA.	74	106	180	112	304	281	1,063

FLM: First Line Management

SDS: Supervising Direct Service

DS: Direct Service

day: Day Programs - does not include programs with audited day rates

res: Residential Programs

*to nearest 1.0

APPENDIX 4

49.

PRIVATE SECTOR STUDYCHD STUDY

<u>CATEGORY</u>	<u>RANGE</u>	<u>MEAN</u>	<u>MEDIAN</u>	<u>AVERAGE RANGE HIGH</u>	<u>AVERAGE RANGE LOW</u>
<u>CLINICAL SUPERVISORY STAFF</u>					
Master	11,400 - 17,840	15,760	15,700	18,670	13,854
Bachelors	10,000 - 17,000	13,014	12,750		
<u>SOCIAL SERVICE PRACTITIONERS</u>					
Masters	10,000 - 16,000	13,327	13,017	14,000	10,400
Bachelors	8,500 14,940	11,081	10,700	12,800	9,400
MSW, no experience				17,000	12,400
MSW, experience				21,00	13,500
Some Graduate Training					
<u>RESIDENCE MANAGERS</u>					
Full Maintenance	8,000 - 11,956	9,909	10,000		
No Maintenance	9,500 - 18,000	12,546	12,600	10,932	9,604
Houseparent				12,298	9,576
<u>CLIENT CARE WORKERS</u>					
Full Maintenance	4,500 -	6,628	7,200		
No Maintenance	6,700- 10,000	8,594	8,490		
House Staff: Adult MH				9,712	8,362
Child Care Workers				10,326	7,642

APPENDIX 4 (Cont'd.)

<u>CATEGORY</u>	<u>PRIVATE SECTOR STUDY</u>			<u>CHD STUDY</u>	
	<u>RANGE</u>	<u>MEAN</u>	<u>MEDIAN</u>	<u>AVERAGE RANGE HIGH</u>	<u>AVERAGE RANGE LOW</u>
<u>VOCATIONAL REHAB. COUNSELORS</u>	7,000 - 12,400	9,970	10,000		
Work Experience Monitor				12,776	11,165
Community Voc. Day Worker				11,333	10,267
Teaching Assistant & Aides	4,000 - 11,950	9,482	7,447		

APPENDIX 3 (Cont'd.)

Composite of Three Residential Programs in Each Turnover Percentage Cohort

Turnover %	Beginning Salary Level	Average Hours Worked	Composite of Agency's Inservice Activities	Vacation Policy - Average of All Staff	Shifts - Direct Care Staff Other Than Social Service Practitioners	Coverage
Exec. Director	15,700	35-60	1:1 once/week			
Sr. Adm. Staff	11,300	60+	Group Supervision/case	fifteen days	Rotate, includes over-nights and weekends	assign staff only; comp time offered.
Supervisory Staff	9,700	40	Conference twice/month	per year (no holidays)		
Social Service Practitioner			Weekly staff meeting			
Mentors N/A						
Mentors 11,500		40+				
Client Care Workers						
Teachers						
Mentors N/A						
Mentors 9,700		40				

APPENDIX 5 (Cont'd.)

Composite of Three Residential Programs in Each Turnover Percentage Cohort

Turnover Cohort	Beginning Salary Level	Average Hours Worked	Composite of Agency's Inservice Activities	Vacation Policy - Average of All Staff	Shifts - Direct Care Staff enter then direct service practitioners	Coverage
Exec. Director	15,700	55-60	1:1 oncs/week			
Sr. Adm. Staff	11,500	60+	Group supervision/case	fifteen days	Rotates, includes overnights and weekends	existant staff only; comp time offered.
Supervisory Staff	9,700	40	Conference twice/month Weekly staff meeting	per year (no holidays)		
Serial Service Practitioner						
Master's M/A						
Reaches 11,500		40+				
Client Care Workers						
Teachers						
Master's M/A						
Reaches 9,700		40				

APPENDIX 6 ACLASSIFICATION USED FOR PRIVATE SECTOR STUDY

Executive Director: Responsible for overall direction and administration of the agency or program. Supervises, delegates, and coordinates functioning of the agency through Board Meetings and supervisory sessions to the Board of Directors and coordinates task responsibilities.

Senior Administrative Staff: Responsible for assisting the Executive in overall agency functioning or who have responsibility for specific aspects of the agency's operation, such as training programs or budget operations.

Supervisory Staff: Assumes responsibility for directing other staff members. Provides clinical and case management supervision to staff members on a regular basis.

Social Service Practitioners: Staff who provide direct services to families and individuals through research: who generally work with clients on a 1:1 caseload basis; are generally responsible for coordinator services and advocacy for the clients in other systems.

Teachers: Staff employed by the program or agency in a school, day program or residential program who are responsible for the evaluation of assigned groups of clients.

Residence Managers: Staff members responsible for daily management and operation of a residential program or unit.

Client Care Workers: Staff, other than nurses, whose responsibilities are daily care and supervision of clients. Provide individual support, guidance and crisis intervention. Assist in the development of daily and long term programming for a specific group of clients, and assists clients in developing personal living skills. Includes house staff counselors and child care workers.

Vocational Rehabilitation Counselors: Staff with responsibility for supervising and assisting clients in pre-vocational rehabilitation programs. Supervises client work groups and transitional employment of clients.

Teaching Assistants and Aides: Staff who assist with client care and training and carry out assigned responsibilities under the direction of specialists, teachers or nurses.

APPENDIX 6BCLASSIFICATION USED FOR DMH-MR STUDY: JOB TITLESFirst Line Management Positions: Residential Programs

Behavior Team Director
 Client Coordinator
 Coordinator
 Director
 Director of Residential Services
 House Director
 Manager
 Mental Retardation Coordinator
 Program Administrator
 Program Coordinator
 Program Developer
 Program Director
 Program Manager
 Program Supervisor
 Project Director
 Relief Coordinator
 Residential Coordinator
 Residential Director
 Residential Services Director
 Satellite Director
 Supervisor

First Line Management Positions: Day Programs

Behavior Team Director
 Community Liason Coordinator
 Coordinator
 Coordinator of Rehabilitation Services
 Day Care Administrator
 Director
 Educational Supervisor
 Plant Manager
 Production Manager
 Program Administrator
 Program Coordinator
 Program Director
 Program Manager
 Program Supervisor
 Rehabilitation Coordinator
 Rehabilitation Counselor Coordinator
 Rehabilitation Supervisor
 Teacher/Director
 Vocational Clinical Administrator
 Vocational Coordinator
 Vocational Programs Administrator
 Work Manager
 Workshop Director
 Workshop Manager

APPENDIX 6B (Cont'd.)

55.

Supervising Direct Service: Residential Programs

Apartment Coordinator
 Apartment Director
 Apartment Manager
 Assistant House Manager
 Community Living Supervisor
 Coop Manager
 Director/ Apartment Manager
 Head Teacher
 House Coordinator
 House Director
 House Manager
 Manager
 Manager/ Counselor
 Manager/ Tutor
 Program Coordinator
 Program Director
 Program Manager
 Program Supervisor
 Residence Manager
 Residence Supervisor
 Resource Staff
 Senior Counselor
 Senior Member
 Senior Program Staff
 Senior Staff
 Site Manager
 Staff Supervisor
 Unit Manager

Supervising Direct Service: Day Programs

Activities of Daily Living Supervisor
 Adult Education Coordinator
 Behavioral Specialist
 Coordinator
 Developmental Disability Specialist
 Developmental Specialist
 Educational Coordinator
 Foreman
 Head Instructor
 Head Teacher
 Home Teacher
 Pre-Vocational Teacher
 Program Coordinator
 Remedial Education Teacher
 Senior Counselor
 Senior Developmental Day Care Specialist
 Senior Instructor
 Senior Member
 Senior Teacher
 Senior Vocational Instructor
 Senior Work Supervisor

Site Supervisor
 Special Education Teacher
 Supervisor
 Teacher

APPENDIX 6B (Cont'd.)Direct Service Staff: Residential Programs

Aide	Residence Counselor
Apartment Coordinator	Residence Manager Assistant
Apartment Manager	Residence Staff
Assistant Apartment Manager	Residential Specialist
Assistant House Director	SALU Counselor
Assistant House Manager	Site Program Manager
Assistant Manager	Skill Instructor
Assistant Program Director	Site Program Manager
Assistant Program Manager	Social Counselor
Back-Up Staff	Staff Advocate
Case Manager	Support Staff
Client Educator	Teaching Specialist
Community Client Manager	Weekend Manager
Community Living Specialist	
Coop Counselor	
Counselor	
Day Care Staff	
Day Program Staff	
Direct Service Worker	
Educator	
Evening Manager	
Evening Staff	
Family Teacher	
Full-Time Staff	
Health Aide	
House Manager	
House Milieu Worker	
House Staff	
Human Service Worker	
Milieu Worker	
Mental Retardation Specialist	
Mental Retardation Technician	
Mental Retardation Technician Assistant	
Night Manager	
Night Staff	
Overnight Aide	
Part Time Aide	
Part Time Relief	
Part Time Staff	
Personal Care Attendant	
Program Aide	
Program Assistant	
Program Instructor	
Program Specialist	
Relief Apartment Manager	
Relief Counselor	
Relief Manager	
Relief Staff	
Relief Support	
Relief Workers	

APPENDIX 6B (Cont'd.)Direct Service Staff - Day Programs

Activities of Daily Living (ADL) Coordinator
 ADL Instructor
 ADL Programmer
 Aide
 Art and Music Instructor
 Assistant Instructor
 Assistant Supervisor
 Basic Education Instructor
 Behavioral Assistant
 Community Assistant
 Community Skills Instructor
 Counselor
 Crafts and Woodworking Instructor
 Daily Living Skills Instructor
 Day Activity Staff
 Day Care Assistant
 Educational Instructor
 Floor Supervisor
 Instructor
 Instructor Aide
 Junior Member
 Junior Programmer
 Junior Staff
 Line Supervisor
 On-the-Job Training Specialist
 Para-Professional Aide
 Placement Specialist
 Pre-Vocational Instructor
 Pre-Vocational Woodworking Instructor
 Production Assistant
 Program Aide
 Program Assistant
 Program Instructor
 Recreation Coordinator
 Recreation Instructor
 Rehabilitation Instructor
 Rehabilitation Planner
 Rehabilitation Worker
 Special Education Teacher Aide
 Special Needs Aide
 Staff Assistant
 Supervisor
 Teacher
 Teacher Aide
 Teacher/Counselor
 Teaching Assistant
 Teaching Specialist
 Training Supervisor
 Tutor
 Vocational Aide
 Vocational Instructor
 Vocational Supervisor
 Work Adjustment Counselor
 Work Supervisor

STATE OF MICHIGAN



JOHN ENGLER, Governor

DEPARTMENT OF MENTAL HEALTH

LEWIS CASS BUILDING
 LANSING, MICHIGAN 48913
 JAMES K. HAVEMAN, JR.
 Director

April 16, 1993

The Honorable Ron Wyden, Chairman
 Subcommittee on Regulations, Business
 Opportunities and Technology
 House Committee on Small Business
 B-363 Rayburn House Office Building
 Washington, D.C. 20515-6318

Dear Congressman Wyden:

I am pleased to have the opportunity to submit to you the enclosed statement of testimony. This is presented for the record of the hearing held March 29, 1993, on the subject of Regulation of Community Residential Services for Persons with Mental Retardation and Developmental Disabilities.

Thank you for your interest on this important topic. Please feel free to contact me if you wish additional information or if I can be of assistance to you.

Cordially,

James K. Haveman, Jr.

JH:bb



STATE OF MICHIGAN



JOHN ENGLER, Governor

DEPARTMENT OF MENTAL HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48913
JAMES K. HAVEMAN, JR.
Director

STATEMENT OF TESTIMONY

On

**The Regulation of Community Residential
Services for Persons with Developmental Disabilities**

Submitted by:

**James K. Haveman, Jr., Director
Michigan Department of Mental Health**

To the

Subcommittee on Regulation, Business Opportunities and Technology

April 16, 1993

STATEMENT OF TESTIMONY

Representative Wyden and Members of the Committee:

My name is James K. Haveman, Jr., and I am the Director of the Michigan Department of Mental Health. I appreciate the opportunity to provide this written testimony on the topic of the provision of community based services for persons with mental retardation and developmental disabilities. I was pleased to learn of your interest in this subject, as evidenced by your recent hearings and year-long examination of related issues.

This written testimony will also furnish responses to the questions which you posed to Mr. Jerry Provencal, Director of Michigan's Macomb-Oakland Regional Center, in your request to him to testify at the hearing. I am aware that he was unable to attend, but I did not want to miss an opportunity to provide relevant information on the topics you are interested in.

As I am sure you know, Mr. Provencal is Director of Michigan's largest community placement agency operated by the State Department Of Mental Health. The Macomb Oakland Regional Center is one of three such community placement agencies which operate under state auspices. Most of the fifty-five county based Community Mental Health Services Boards, which comprise the majority of the public mental health system in Michigan, also provide community residential services for persons with developmental disabilities.



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In Michigan, we are very proud of the extensive community based system which has developed in the past 25 years. In 1976, the census of our state institutions which serve persons with developmental disabilities exceeded 12,600. Today it is less than 485. During our history, we have operated 13 DD Centers. Now only three remain open, and we are developing plans with the Community Mental Health Services Boards to phase those out when we have the requisite community support services in place to serve/support the people who still reside there. Generally these are people with very complex medical conditions or with very challenging behaviors, so our planning will have to be very thorough as we arrange for the necessary services. We strongly believe that community based options are preferred and should be possible for most everyone, given the necessary services and supports.

At the current time, there are about 7500 persons with developmental disabilities who receive community based specialized residential services in Michigan. This means that they live individually with supports, or in small settings such as foster care or small group homes, and receive supports and/or habilitation training services through a public mental health agency, either a state residential services (placement) agency, such as the Macomb-Oakland Regional Center, or a Community Mental Health Services Board. In addition to the residential services, these persons also receive support services such as school, work or occupation-related



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day activity, sheltered workshop, or supported employment. They all receive mental health case management, unless on an individual basis they do not wish that service.

We should also point out that in Michigan there are 25-30,000 additional persons served through our adult foster care system. These are people of varying characteristics, but most would be within the category of "aged and disabled". Since they generally do not receive specialized residential services through the public mental health system, they are not included in this discussion.

Funding for services for persons who do receive public mental health residential services comes from a variety of sources. Residential services for about 2000 people are funded under the Intermediate Care Facility Program for the Mentally Retarded (ICF/MR), which of course combines state and federal funding. An additional 2000 are served through our Medicaid Home and Community Based Waiver. Case management services are funded by our Medicaid Target Case Management Coverage. Day services are funded in part by state general fund revenues, in part under Medicaid Clinic Services and Rehabilitation Services optional coverages, and in part by Michigan Rehabilitation Services. Workshops also generate revenue through their contract work. All consumers who are school age attend educational programs, funded through the Department of Education. In addition, many consumers avail themselves of other



Page 4

services such as Personal Care, Home Health Services and similar services, frequently funded under Medicaid, and available to eligible citizens of our state, both those with disabilities and those without. We have designed our service system so that consumers have as much opportunity for inclusion and integration as possible, using the same generic resources that are available to all citizens.

One of your areas of expressed interest was whether or not the needs of the MR/DD population are adequately being met. In Michigan, we have made a considerable investment in seeing that the needs are met. In 1992, costs for the residential services which are provided through the public mental health system for the 7500 persons with developmental disabilities, exceeded \$400 million. We should point out that were these same persons to be receiving services in our DD Centers, the cost would have exceeded \$800 million, at current ICF/MR rates. Of course issues related to cost are important, but they are certainly not the foremost considerations which guide our policies. We firmly believe that people with disabilities ought to live in homes, in families, and in communities. They not only thrive and prosper in community settings, but they have a human and civil right to live where they choose. In support of those beliefs, Michigan has several current initiatives which are designed to encourage consumer choice and independence. We have pursued creative funding options which have



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enabled consumers to purchase homes of their own. We have established statewide policies on inclusion and housing which articulate our dedication to supporting people, and encouraging their independence. We are also developing Quality Improvement programs which are focused on consumer outcomes, and which involve consumers in service planning and analysis.

Meeting the necessary service needs and providing adequate oversight in a decentralized system does present us with challenges. One means by which we meet such challenges, is through the implementation of a legal rights protection system, as mandated by the Michigan Mental Health Code. We also have both Children and Adult Protective Services through the Department of Social Services, and state licensing for adult and children's foster care and group/congregate living arrangements. Additionally, we are in the final stages of developing Administrative Rules governing a certification process for licensed settings which provide services to this population. The process will stipulate standards which providers must meet if they are to provide residential services for recipients of mental health services. Also, many homes are currently certified under other programs such as the ICF/MR Inspection of Care process or a similar certification process which we have implemented in our Home and Community Based Waiver homes, and for our Medicaid Clinic Services/Rehabilitation Services providers. We have also worked with our advocacy organizations such



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as ARC Michigan who has, with our support, implemented a residential monitoring program. Under this program, ARC representatives visit community residential homes for the purpose of observing the condition of the home and its residents, and also serving as "good neighbors" in the event there is a need.

You expressed interest in the issue of how the system should be balanced so that the health and safety of vulnerable populations can be protected, and yet maintain a balance with the need for appropriate oversight. This has certainly been one of our biggest challenges. Historically, we have been very sensitive to the need to provide appropriate protections for vulnerable populations. These protections have taken a number of different forms, as you can see from the above list. In fact, one of the most consistent complaints we hear from our service providers, and often from the consumers, is that the frequent and often duplicative nature of the various surveys and reviews become very burdensome and intrusive. Thus it is an on-going dilemma. We do acknowledge that no system, no matter how regulated, can guard against all contingencies. There are occasional circumstances when vulnerable people are victimized. Sometimes such situations occur because people exercise their right to choose, and they do not make wise choices. But other times, our eyes and ears fail us, and we must improve our systems so that such situations are not repeated. This is quite comparable to the ways in which the institutional system was called



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upon to remedy the problems of past decades. We find that one of the advantages we have when we are correcting such problems in a community system is the level of visibility which exists. The numerous contacts which people have in community locations do provide more eyes and ears, and the remedies are generally swifter and better because of continued visibility, than they would be in a hidden segregated location. But we must point out that adding more regulation to an already highly regulated system is usually not the answer. Although states vary in their methods, generally all have regulatory mechanisms to govern their community services. Also, most states avail themselves of the various Medicaid programs, all of which require compliance with federal requirements. The system works best when the federal government meets its obligations to oversee programs serving vulnerable populations, by requiring the states to develop plans to assure the protection of health and safety, and by monitoring states' compliance with their own plans.

Michigan recently experienced several incidents which raised questions as to the care afforded to vulnerable adults in this state. In response to the need to assure appropriate monitoring within Michigan's systems, Governor Engler directed Gerald Miller Ph.D., Director of the Department of Social Services, and I to convene a task force to look into the various oversight responsibilities and how they are being carried out. We were able

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to identify areas which called for better accountability and procedural controls as well as some areas where state regulations needed strengthening. We are making changes in identified areas such as improved Recipient Rights protections, increased adult foster care licensing capacity, legal sanctions for certain provided violations, etc. We will continue to make modifications as necessary. We remain convinced, however, that such regulatory oversight, including establishment of standards, assurance of compliance, and initiation of corrective actions, belong at the state level.

You also expressed interest in several aspects of our provider system. It has been necessary for us to develop a very extensive provider network in order to serve the many people we do. Community based services under state auspices are all provided by private contractors, predominately private non-profit vendors. Most Community Mental Health Service Boards also contract with private vendors. The vendors employ their own staff, and state employees are not employed in these settings, although state employees within community placement agencies do provide monitoring and clinical support. The policy which guided this decision was our belief that if state employees were to follow the recipients and be employed in community residential settings, true inclusion of our recipients into community life would likely not occur. We still believe this to be the correct policy.

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Probably our biggest dilemma with this policy is that the staff salaries offered by private vendors are often inadequate for retaining a well trained workforce for the long run. Currently the appropriations which fund our residential services only allows for an average annualized wage of \$9.06 per hour per FTE. However, since the contractor must also pay fringe benefits out of this amount, it falls short of what is needed. We have advocated for resources to provide more competitive wages, but funding has not kept pace in these difficult fiscal times. We believe that this continues to be a problematic issue, and needs resolution. The wage factor additionally impedes the provider's ability to attract good quality staff. Equally important, however, are the contractor's ability to manage and utilize resources efficiently.

Our vendors recruit and screen their own prospective employees. They are obligated by licensure in Michigan to assure that their employees are of good moral character. That is understood to mean that employers must assure that the people they employ do not pose some type of threat to the residents. Employers generally do background checks including checking arrest and conviction records. Michigan also currently maintains a register of suspected child abusers, but it is currently only available to our Department of Social Services. It is kept as a safeguard against employing persons with such histories in the foster care or child caring systems of that agency, or against issuing foster care licenses to

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applicants with undesirable backgrounds. We are attempting to get agreement for mental health agencies to have access to that same information in order that we may better protect the vulnerable populations we serve. Currently it is difficult to access adequate information for this purpose. Additionally, the Department of Public Health maintains a nurses aide registry which we can access. This registry lists persons who have successfully completed training as nurse aides, and therefore have skills which may make them suitable as staff for residential vendors.

We also have required training components for residential providers and their staff. These range in topic areas from basic health and safety, including First Aid, CPR, and nutrition, to methodologies for individual treatment programs. However, because of rapid staff turnover, providers often rely on on-the-job assistance and training by other staff, rather than formal training.

You also expressed interest in whether our providers own the community residences. For reasons similar to our policy on employees, we likewise do not own the community residences, nor do we currently permit the service vendors to own them (although some may retain ownership of property obtained prior to implementation of this policy). Because our policies are designed to encourage independence, we want to have a system which facilitates consumers moving to their own homes, or to less restrictive settings with the

Page 11

amount of necessary support but which will minimize intrusion, as soon as they are able. Property owners who have a vested interest in retaining residents could impede such a policy. This same policy of dispersing "controlling" elements extends to providers of day programs or supported employment.

We also believe that it is not wise practice to encourage a single provider to offer services to too many consumers or in too many homes. We have had a longstanding policy that one vendor can not contract for more than twelve homes with the Department. Some however, also hold contracts with community mental health boards in addition to the department, and may in that way exceed twelve homes. The limit was set somewhat arbitrarily, but was done so that we would not find ourselves in the position of having to make alternate living arrangements for large numbers of people in the event that a provider ceased doing business with us. Currently there are about 2000 contracts under which specialized mental health residential services are provided in Michigan. I would say that we have been able to maintain an adequate supply of provider organizations so that we are able to find alternate vendors if needed. We do have vendors who choose to discontinue providing services, although that is infrequent. Also, we do cancel contracts due to poor quality services and/or fiscal mismanagement. We do not prohibit the providers from having ownership interest in other types of contract services, but their ownership interests



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must be disclosed. We do have state laws which prohibit conflict of interest, and have referred such questions to the state Ethics Board when we felt the need. Additionally, most of our provider contracts are cost settled annually, and monitored against our guidelines which delineate the purpose for, and the accounting of, expenditures. Provider contracts are also subject to audit by departmental auditors as well as the Michigan Office of the Auditor General.

I realize that my responses are lengthy, and I appreciate your patience in allowing these issues to be discussed fully. We applaud your on-going interest in assuring necessary protections for vulnerable populations. WE FEEL STRONGLY, HOWEVER, THAT MORE REGULATION IS NOT THE ANSWER. In Michigan we are very encouraged by the experiences of people who participate in our Community Supported Living Arrangement (CSLA) program, through which Michigan was funded as one of the eight pilot states. In that program, we were allowed the latitude to define our own quality assurance mechanisms, and by so doing, we have developed services and supports which much more closely meets the needs of consumers. The monitoring mechanisms allow the consumers to participate in the evaluation of their own providers, and employ community members to assist in the monitoring activities. Because of the assistance consumers receive from their own communities, abuses are much less likely to occur than in any of our already rigidly regulated



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programs or settings. While I realize that such individually tailored situations do not lend themselves to standardized monitoring mechanisms, they are much more cost effective for the system, and the outcomes are better for people. We see no reason why such a tailored, state specific plan meeting standardized outcome criteria cannot meet everyone's needs.

Thank you for the opportunity to provide this testimony. My staff and I stand ready to be of any assistance we can if you wish to explore these issues further.





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FOR THE MENTALLY DISABLED
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CLARENCE J. SUNDAM
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ELIZABETH W. STACK
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COMMISSIONERS

April 26, 1993

Hon. Ron Wyden
Chair, Subcommittee on Regulation
Committee on Small Business
1111 Longworth House
Office Building
Washington, DC 20515-3703

Dear Congressman Wyden:

I recently received a copy of the report of the Committee on Small Business concerning the problems of abuse, neglect and financial exploitation of people with mental disabilities living in the community.

As you may be aware from previous correspondence, the New York State Commission on Quality of Care is a unique, independent state commission charged with overseeing the quality of institutional and community programs. In addition to investigating allegations of abuse and neglect and serving as the state's Protection and Advocacy agency under federal laws, our Commission also conducts cost effective studies and fiscal investigations to ensure that public money is being appropriately spent to meet the needs of the intended beneficiaries.

Our investigations over the past decade illustrate many of the problems cited in your Committee's report. The comprehensive fiscal investigations we have conducted have identified waste, fraud and abuse amounting to tens of millions of dollars annually and have prompted state actions to revoke licenses, condemn property, and successfully seek recoupment of public funds and damages.

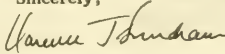
We have noted that in virtually every instance where we have found financial wrongdoing, the so-called independent accountants of not-for-profit corporations have actively misled government regulatory agencies by filing misleading or false financial statements. The Commission believes that an effective method of curbing financial fraud would be to place such accountants on notice that government agencies rely on their opinions about the financial

integrity of not-for-profit corporations. Thus, if they mislead such government agencies through false or grossly negligent accounting practices, they could be held liable for the ensuing diversion of public funds.

The Commission believes that such a change in existing practices would go a long way towards adding a deterrent to the types of financial improprieties your committee has reported upon, without requiring a massive investment of public funds to add auditing staffs to state and federal regulatory agencies.

If you need any further information, please let me know.

Sincerely,

A handwritten signature in dark ink, appearing to read "Clarence J. Sundram". The signature is fluid and cursive, with the first name "Clarence" and last name "Sundram" clearly distinguishable.

Clarence J. Sundram
Chairman



OFFICE OF
COMMISSIONER
DONALD G. WISEMAN

UNITED STATES OF AMERICA
OCCUPATIONAL SAFETY AND HEALTH REVIEW COMMISSION

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April 2, 1993

The Honorable Ron Wyden
U.S. House of Representatives
2452 Rayburn House Office Building
Washington, D.C. 20515-3703

Representative Wyden,

As a parent of a mentally retarded son living in a North Carolina group home, I applaud your efforts to reform the system.

I have served six years on the North Carolina Council on Developmental Disabilities and continue to serve at the pleasure of the Governor. In that capacity, I have been a Member of the Employment Related Activities Committee and very involved with employment practices as they relate to persons with disabilities in the workplace.

My concerns certainly seem to parallel yours in the lack of confidence parents and others can have in a system that periodically surfaces with some grotesque story or a perverted person taking advantage of these very vulnerable citizens. In fact, such was a case in North Carolina that affected my son and his room mate when at least one client was sexually abused by a staff person. Since that time, my wife and I have lived in fear of what happens to Terry, our son, when we are no longer here to watch over him.

Another deep concern I have as a safety and health professional is how do employers and employees with disabilities comply with OSHA standards with their unique circumstances, (i.e. visual impairment, mental retardation, muscle control difficulties etc.) I have pulled together a group of persons on the national level that represent persons with developmental disabilities with the objective of moving OSHA in a direction that will assist employers and employees with compliance.

NOT PAID FOR AT GOVERNMENT EXPENSE

Again, Congressman Wyden, I deeply appreciate your efforts and offer to you any assistance that I can give.

Sincerely,

A handwritten signature in dark ink, appearing to read "D. G. Wiseman", enclosed within a simple oval scribble.

Donald G. Wiseman

Illinois University Affiliated Program in Developmental Disabilities (M/C 627)
1640 West Roosevelt Road
Chicago, Illinois 60608
(312) 413-1647 Fax: (312) 413-1326
TDD: (312) 413-0453

**Testimony of Dale Mitchell, Ph.D.
University Affiliated Program in Developmental Disabilities
University of Illinois at Chicago**

My name is Dale Mitchell and I am the Assistant Director for Program Development at the Illinois University Affiliated Program. This program is located at the University of Illinois at Chicago and is part of a network of fifty-one programs affiliated with major universities in forty-three states. I have had sixteen years of direct care and administrative experience in both state-operated and community based MR/DD facilities. I have a PhD in Public Health and a Masters degree in Public Administration.

For the past six years I have conducted and published research on several areas in the MR/DD field. This research has included public expenditures for MR/DD programs, the effect of nursing home legislation on persons with developmental disabilities, and the compensation of direct care workers in residential facilities. I have published several articles, books, book chapters, and technical reports on these topics. In addition, I have also made numerous presentations before professional MR/DD organizations.

I have restricted my written testimony to issues related to the compensation and retention of direct care staff. I was Project Director of a nation-wide study in FY 1990 on the compensation and turnover of direct care staff working in residential MR/DD facilities. This study utilized representative samples from all fifty states and the District of Columbia. More than 1,000 surveys were received from public institutions, privately operated community facilities, and publicly operated community facilities.

Starting wages

The mean starting wage for direct care workers in privately operated community-based MR/DD facilities in 1989 was \$5.22. This compared to a mean starting rate of \$6.85 in public institutions. Only one state (Connecticut) reported a mean starting rate above \$8.00 for its private community facilities while seven states reported a mean rate above \$8.00 for their institutions. Six states reported mean starting wages below \$5.00 for its publicly operated institutions while 31 states had mean starting wages at or below \$5.00 for private community facilities.

Average wages

The mean average wage for direct care workers in privately operated MR/DD facilities in 1989 was \$5.97, compared to \$8.72 for direct care workers in public institutions. Sixteen states reported a state-wide mean average wage rate at or above \$9.00 for their publicly operated institutions while only two states (Connecticut and Nevada) reported such a wage level for privately operated community facilities. In comparison, only two states (Mississippi and West Virginia) reported a mean average wage below \$6.00 for their public institutions while 31 states reported rates that low for their private community facilities.

Comparison of wages to other industries

The average national wage of direct care workers in privately operated MR/DD facilities in 1989 was \$5.97. Bureau of Labor Statistics data indicated that the typical worker in the private sector in 1989 earned a great deal more than this. In 1989, the national average hourly wage for private workers in non-agricultural occupations was \$9.96. Wages for these industries ranged from a low of \$6.54 per hour in retail trade occupations to a high of \$13.54 per hour for construction occupations.

Benefits

Information was collected on six different types of employee benefits offered to full-time direct care workers. These included health, dental, retirement, child care, tuition assistance benefits, and paid days off. Data was collected regarding whether the benefit was offered by the facility and not on the comprehensiveness of the benefit offered itself. In terms of paid days, facilities were asked for the number of paid holiday and vacation days off earned each year by employees (after one and five years of employment).

Nearly all of the public and private facilities offered some type of health plan to their workers (100% and 96.8%) while a slightly smaller proportion included dependents in the coverage (99.4% and 92.1%). However, considerably fewer of the privately operated facilities offered a dental plan to either their workers (63.8%) or their dependents (59.4%) than did the publicly operated institutions (93.7% and 93.2%).

Nearly all public institutions (99.4%) offered a retirement plan to their direct care workers while only slightly more than half (56.8%) of the privately operated community facilities did so. A much larger proportion of public institutions (23.3%) provided a child care benefit than did privately operated community facilities (2.6%). Similarly, a greater number of public institutions (63.1%) provided some type of tuition assistance than privately operated community facilities (30.0%).

In terms of paid vacation and holidays, after one year on the job, direct care workers in private facilities earned approximately five fewer paid days off (18.2 vs. 23.4) than did their counterparts in public institutions. After five years on the job, this differential had decreased (23.4 vs. 26.7) but still existed.

Turnover

The mean turnover rate for direct care workers in privately operated MR/DD facilities in 1989 was 70.7%, compared to 24.8% for direct care workers in public institutions. Thirty-nine states reported a state-wide mean turnover rate at or above 50% for their privately operated community facilities while only five states had rates above 50% for their institutions. More than one fourth (26%) of the privately operated community facilities reported turnover in excess of 100% while only one percent of the public institutions did so.

The national mean length of service for full-time staff who left in responding private community facilities was 14.7 months, compared to 50.3 months for staff in public institutions. More than half (55.9%) of the direct care workers who left their jobs in privately operated community facilities did so before completing one year on the job.

Quality care

It is reasonable to conclude that an adequate wage is at least a prerequisite for quality care in the human service occupations. The mean starting wage for direct care workers in privately operated community facilities (\$5.22) was only 3% above the poverty level for a family of three in 1989. The number of direct care workers who were actually living in poverty could not be determined since the number of family members and the amount of other family income would have to be known and considered. However, more than one half of the private facilities reported starting wage levels for their full-time workers that were below the poverty level for a family of three.

Compounding the problem of low wages has been the failure of these wages to keep pace with inflation during the past decade. In real economic terms, the mean starting wage for community facility staff declined by 15.4% between 1981 and 1989. Similar findings have been reported for the real wages of direct care workers in health and child care settings during the 1980s.

Minimum skill and training requirements

The most frequently reported pre-employment requirements among the states were based on age, education, possession of a driver's license, prior experience, special training, and previous criminal record. A majority of the public institutions

(73.5%) and the private community facilities (94.7%) reported a minimal age requirement. The majority of public (52.9%) and private (92.4%) facilities also had a minimal education requirement. Almost one third (29%) of the private facilities required the applicant to have a driver's license compared to only 6% of the public institutions. Less than one tenth of the public (3.8%) and the private (7.5%) facilities automatically disqualified an applicant if they had a criminal record. Very few of the facilities required any special training in the field (public-2.3%, private-3.1%). However, a number of the private facilities (15.3%) required previous work experience in the MR/DD field, compared to 7% of the public institutions.

Nearly all public institutions (99.4%) and private community facilities (89%) reported that they required classroom in-service training for new direct care workers after they were hired. A slightly smaller proportion of facilities (90.3% and 79.9%) reported that they provided formal on-the-job-training (ojt). The public institutions in the national sample provided more than twice the number of classroom hours of training (93.2 hours) than did the privately operated facilities (36.6 hours).

Summary and conclusion

Wages for direct care staff, already near the poverty level ten years ago, have failed to keep pace with inflation during the last decade. The rate of direct care turnover has increased during that same time and is over 100% per year for more than one-fourth of the private community facilities. It is clear that the wages paid to direct care workers in most private community facilities must be increased substantially if the workforce is to be stabilized. Without a more stable workforce, quality care will be very difficult, if not impossible to provide to persons with developmental disabilities.

Despite inadequate wages and high turnover of direct care workers, action by public officials to correct the problem appears to be quite limited. A national survey conducted in 1990 reported that nearly half of the states (twenty-two) had implemented no policy initiative to improve direct care wages. Most of the states which have implemented some type of policy initiative have restricted their activity to either the creation of a task force to study the problem or enactment of a one-time wage adjustment. While future research is needed to further clarify factors other than wages which may affect turnover, significant improvement in the compensation of direct care workers is needed now as a first step to minimize turnover and stabilize the workforce.

Voice of the Retarded

2800 Central Road
Rolling Meadows, Illinois 60008

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March 22, 1993

The Honorable Ron Wyden
Chairman
Subcommittee on Regulation,
Business Opportunities and
Technology
2452 Rayburn Building
Washington, DC 20515

Dear Representative Wyden,

Thank you for inviting my submission of written testimony for the record. Should you need further information, I will be at home after April 2, 1993.

VOR greatly appreciates your interest in Medicaid fraud, which impacts quantity and quality of service delivery for our Mentally Retarded/Developmentally Disabled persons, regardless of where they live.

Sincerely,

Polly Spare

Polly Spare
President

encl.

My name is Polly Spare. I am President of the Voice of the Retarded, 2800 Central Road, Rolling Meadows, Illinois 60008. I reside at 210 Hillendale Drive, Doylestown, PA 18901. Voice of the Retarded is an organization of parents, family members, providers, professionals, friends, and affiliated groups, in 47 states, who are involved with people in institutional settings, community living arrangements, or at home. We strongly believe that a spectrum of services must be available to meet the diverse needs of persons with mental retardation.

I am founder and President of the Pennsylvania League of Concerned Families of Retarded Citizens, Inc., P.O. Box 1133, Doylestown, PA 18901. I was certified as an advocate under a Federal Court Order in Haldeman v. Pennhurst, and I have had 35 years of experience developing/evaluating programs for persons with mental retardation. Earlier, I had provided this committee with documentation as to the outcome of deinstitutionalization, based upon my experience.

I regret that it is not possible for me to testify in person on March 29, 1993. Thank you for inviting me to submit testimony.

I am concerned that Medicaid funding for our most disabled mentally retarded population is systematically being redirected to support a philosophically and ideologically oriented movement. Many people involved in this pursuit are profiting from the community paradigm, which does not recognize the existence of that segment of our handicapped population that statistically will never lend credibility to their narrow objectives.

New and well-researched cost-effective approaches that expand the range of alternatives are always welcome, but not at the expense of the proven initiatives. Advocates for change seem to rely, repeatedly, on "out with the old, in with the new". The expanded availability of waiver funding has stimulated private interest. I would like to think that the rapid expansion of privatization was a humanitarian objective. I was present at a Pennsylvania conference when one of the Commissioners of Mental Retardation was "selling" the small group home program. She promised the world! Today, it's considered by some professionals to be "a professional error, as institutionalized as the institutions".

I am involved with persons who have successfully transitioned, but I am also painfully aware of people who have a "low" priority on residential waiting lists. These people are regressing at home, because workshop placements are not available after "graduating" from federally mandated education programs (94-142). In Pennsylvania, there has been no expansion money for workshops for two years. The new paradigm is supported employment in community settings. Emphasis is on independent living with supports, a program offered to people who are not always competent to make rational choices. They are at risk in this system without a revolving door policy that allows return to a facility for further community preparedness. The only alternative for persons with mental retardation, in states that are downsizing institutions with a no-return policy, is commitment to a psychiatric hospital or jail.

- 2 -

I would consider support for any proposal that offers choice and an opportunity to access, without prejudice, an individually determined, appropriate service. VOR supports the Hub and Satellite model as one alternative. We would be happy to explore this further with the Committee.

On March 17, 1993, Budget Director Leon Panetta ordered a government-wide review of service contracts with private business, seeking procedural reforms and evaluating cost effectiveness. At state and local levels, providers who are recipients of Medicaid funding should be evaluated annually by an INDEPENDENT review board. Interested taxpayers are entitled to know if contracts are accomplishing what was intended, if programs are cost effective, and if they are adequately monitored for quality. Such evaluations could be accomplished using trained volunteer personnel.

I am the parent of two profoundly retarded adults, ages 37 and 40, who reside at Woods Services, Langhorne, PA. Sandra, the elder, spent over 15 years without incident at the notorious Pennhurst Center, PA prior to her present placement. She has medical complications due to thoroso-lumbar scoliosis, venous insufficiency and osteoporosis. Her mental age is 12 to 18 months. She has been at "Woods" since 1984.

The remainder of this testimony will focus on my son Christopher who, just prior to his present placement spent three traumatic years in three small community homes operated by a for profit provider of 50 small Pennsylvania group homes, ALL licensed by the Pennsylvania Department of Public Welfare. In fairness to this agency, I must admit that no other provider would consider Chris, a medically and physically fragile man, allergic to haldol, valium, phenolbarbital, etc., as well as anesthesia (he stops breathing). He has no response to any antibiotics. His mental age is 9 to 12 months, his life has been a series of crises - some life threatening.

A November 1986 settlement agreement in a pending abuse case guaranteed him lifetime care in a place that met with our approval - exactly what we had sought. Damage claims were not involved. Five facilities rejected our application on his behalf, LH (the group home provider) accepted him on a waiver of the 2176 Medicaid waiver, allowing institutional funds to be used in community settings. At that time the basic waiver was \$145 per day.

- 3 -

His first home was much too small. The environment proved to be chaotic. The grouping for all residents was inappropriate - a 14-year-old boy, non-ambulatory, Chris, and a non-ambulatory higher functioning adult female. Predictably, Chris responded very poorly. His behaviors escalated. He destroyed property and hyperactivity resulted. Close neighbors were hostile. Programming required by the 2176 waiver existed on paper, but it was ineffectual. More staff was needed, but not available. There was neither adequate funding nor space to serve the individual needs of these people. We resisted attempts to control his behavior by experimenting with psychotropics.

Eventually we negotiated a transfer to what they presented as "a charming old farm house with a fenced in yard". Our site visit revealed multiple deficiencies in a house that had FULL licensure:

1. Cement steps at the entrance had to be rebuilt to prevent injury. (They were patched, not replaced.) A railing was added to assist Chris who has limited vision.
2. We requested a first floor powder room. We got an adult potty chair in the laundry room to replace a bucket that was being used as a convenience by the other two men.
3. A dishwasher was installed. Both men were hepatitis carriers. Chris had been immunized.
4. A narrow open staircase leading to a dirt cellar was closed off.
5. An exterminator controlled roaches in the kitchen and mice in the cellar.
6. Windows were replaced in the upstairs bedrooms. Panes of glass were broken and the sashes would not stay open without a prop. Storm windows were installed.
7. Furniture and blinds were repaired or replaced.
8. The interior was painted.

The staff kept thanking us for our intervention. The other men had no family involvement and no advocates.

During his residency in that program, the septic system and the well malfunctioned. They were too close. Bottled water was brought in, baths were on hold. Open trenches for the septic lines remained exposed for several months in violation of regulations.

- 4 -

Christopher had multiple hospitalizations at 3 to 6 month intervals for pneumonia and dehydration. At one point, for a period of several weeks, he suffered from a neurological disturbance manifested by total lethargy, was unresponsive and unable to stand or sit up. This was complicated by what appeared to be myoclonic seizures - tremors and head dropping. Between EEG's, X-rays, lab tests and doctors visits for evaluation, he lay on a mattress in the living room to be in field of vision at all times. Probable cause of the illness was viral.

Chris never fully recovered. He was again hospitalized with a 104 degree fever and even more acute symptoms. For eight days he was attached to a 24 hour video-computer brain scan which revealed almost complete brain injury, but no obvious seizure pattern. Earlier brain studies had indicated a cortical midline brain injury. We will always question how the damage became so pervasive. At that house he also suffered a broken leg, a dislocated shoulder, swollen fingers, black and blue toes and multiple bumps about the face.

Staffing changes became obvious about 2 months later. By now, Chris appeared greatly improved. Senior house staff never seemed to be on duty when we called or visited, and when I asked for a call back I learned that there had been a van accident - the staff was out on disability - the van was totalled. The men were in the vehicle at the time of the accident but were not taken to the hospital to assess possible injury. Chris had black eyes, a large (2-1/2") lump (hematoma) on his forehead and an enlarged deformed ear that remained swollen shut for several months. We never got satisfactory answers to our questions, but at a follow-up appointment with the neurologist, he indicated this could only have resulted from a severe blow, most likely the accident.

More meetings, more conference calls and Chris was offered a new house with a private first floor bedroom and bath. It was more homelike, but once again needed a dishwasher. Just before Christmas 1990, Chris was hospitalized for pneumonia - this time, at our insistence, at a teaching hospital. On admission, we were told that he was dangerously dehydrated (life threatening.) His repeated pneumonias were diagnosed as "aspiration." He had open bed sores for which they provided a special mattress. There was a nutritional assessment, a special dietary routine, and upon discharge three weeks later, a conference including hospital personnel, medical staff and the provider agency. We were told that he required daily observation by a visiting nurse and an ongoing assessment by a dietician for treatment of his malnutrition.

- 5 -

We found it hard to believe that his needs had been so poorly met. Within two weeks we observed first hand what had probably contributed to his debility. Staff suggested that I look in the refrigerator. There was no milk, no juice, no fruit, and no vegetables. The freezer had 1 package of four (4) frozen chicken thighs. There were two cans of turkey gravy and four potatoes to feed four adult men that evening. We were horrified! She was fired.

Christopher's placement agency responded quickly, and we made application for him at Woods Services.

Chris has found a permanent home at last. We know that he will continue to experience crises, but we have peace of mind knowing his needs are being met by a facility large enough to support on-site professional personnel.

March 24, 1993

Senator Ron Wyden and Members of the Subcommittee on Regulation, Business Opportunities, and Energy:

My name is Jeanne Anne Walsh. I am a retired public school teacher living in Fort Washington, Maryland which is in Prince George's County. I am the mother of a profoundly retarded, cerebral palsied, quadriplegic, diabetic man who lives at Great Oaks Center, a state operated institution in Silver Spring, MD. I am a past president and current member of the Great Oaks Association, an organization of parents, relatives, and friends of Great Oaks Center residents. In this organization, I am chairman of a Volunteer Parent Advocacy Committee formed last October to make visits to residents of Great Oaks who were being transferred to community group homes in a downsizing effort and who had no family involvement. Our purpose was to ease their transition. We were given four residents to visit.

One lady moved into a home two streets away from mine operated by Southern Maryland Vocational Industries. She is 50 years old, has Downs Syndrome, does not speak or communicate in any way, and has many eating/drinking problems. She is on thyroid medication, eyedrops for glaucoma, and her weight (about 50 lbs.), bowel movements, and tendency towards athlete's foot need constant monitoring. Her balance is poor, even with a walker, so that she needs assistance when walking. She has no teeth and must have only pureed foods. In November, this lady became severely dehydrated and spent many weeks in a hospital stay which included a bout with pneumonia. Her dehydration was discovered as a result of a last minute decision to include her on a trip to the doctor intended for another house member because she wasn't acting quite right. (The doctor is a good 35 minutes away because the ones in the vicinity will not take Medicaid and/or retarded patients). She returned to the home again for about three weeks. On Jan. 18, she was severely scalded by hot water in the bathtub. She gave no indication that she was being burned. The caregiver discovered her red, peeling skin as the water flowed out of the tub after her bath and hair wash. She was treated in Intensive Care at Washington Hospital Center's burn unit from Jan. 18 til Feb. 16 and was released from the hospital on Mar. 5. She is now back at her group home and is said to be healing well.

The lady involved in this incident is no longer working at the home and the other staff member who worked with her has reportedly found other employment. Both of these people are very pleasant, caring, well intentioned, and probably in their early twenties. I don't think they were trained well enough to care for someone with this lady's many problems.

At Great Oaks, nurses make the rounds regularly giving medications and are immediately aware of medical concerns. A doctor is always on duty and an infirmary handles acute cases for as long as is necessary usually on a one to one ratio. What is not understood by those who advocate independence for all mentally retarded is that it takes a very long time of treating and caring for each multi-handicapped, profoundly retarded individual to be able to recognize his danger signals of severe health problems when they present themselves.

The second former Great Oaks resident we visit is a 65 year old man who has been institutionalized since childhood. He takes 300 mg of Dilantin and 120 mg of Phenobarbital each day which did have his seizures under control until two days before his departure conference when he had one. He has osteoporosis involving his spine, knee, and right breast. He fractures easily, has a severe hearing loss, and glaucoma. This man is subject to severe ear infections which have been kept under control by dolomite irrigations which must be done once a week by one who is trained. He has problems with dry skin and constipation. (His skin is described as extremely sensitive.)

This man is rated with a profound cognitive deficit (IQ of 9). His weakest area is social skills. A major problem is his inappropriate sleeping. He will try to find a place to lie down all during the day. His doctor has said perhaps all his medications cause this, but as he has little appreciation for daily routines, he may be bored. He must be watched closely. He walks well and fast and will go through any door because it is there. He becomes disoriented when walking somewhere and will go somewhere else. He toilets independently but must be encouraged to use toilet paper. He shaves, brushes his teeth, and manages all his self care needs but someone must be with him at all times. This man has a propensity for eating nonfood items, has hallucinations, steals food, has a mild problem of spitting and hitting about one to three times a month, and exhibits noncompliant, uncooperative behav-

for one to six times a week. Handflicking and mouth clicking occur about once an hour. His speech and language are said to be at a 20-26 month level, he likes things in order, can put shapes into a puzzle, and can identify colors and write his name.

This man was living for about two months in an ARC home in Clinton until he fell down the basement stairs and broke his hip. He's now back at Great Oaks recuperating from his operation because he needs 24 hour care which the group home cannot supply.

Nelson J. Sabatini, Secretary of the Department of Health and Mental Hygiene for the State of Maryland assures me that both of these incidents have been thoroughly investigated by the provider agency, the Southern Regional Office of the Developmental Disabilities Administration, the Community Capacity Team of the University of Maryland at Baltimore, and the Office of Licensing and Certification. The Maryland State Police conducted a separate and thorough investigation of the accident where the individual was scalded.

The third and fourth residents we had were placed in a Mt. Hebron, MD home run by Family Services Foundation. The woman is fed by means of a gastrointestinal tube and does not communicate. Both wear plastic molded "jackets" to enable them to sit. This home was closed by the regional director after about 3 weeks for numerous violations and its residents returned to Great Oaks. New staff were trained at Great Oaks and those residents returned to the home about two weeks ago. We were pleased that problems were noted and action taken quickly, but this type of person often cannot handle change well. It had to be a very traumatic experience for them.

As a parent, my question is, "Why put people like this through such trauma?" For them as individuals, have they anything to gain by being moved from a medically secure, well programmed, and well nurtured environment and put into separate, isolated, albeit attractive, house with caregivers inexperienced and untrained in the needs of the severe and profoundly retarded because some people think that this is the 'normal' way for everyone to live?

As parents, over many painful years we have come to realize that our children are not normal and never will be. Some are minimally trainable but lasting progress with them is sporadic, usually regressive, and usually short-lived when achieved. They are at the bottom end of the range of mentally retarded persons (0-70% IQ). They are below 10% IQ, many have multiple physical handicaps, and many are behaviorally maladapted. Their total care and protection in a large congregate facility whose permanence is assured is the hope of most parents of the severe and profound that I know.

I say a large congregate facility because we believe in the "safety in numbers concept. All types of abuses (financial, sexual, etc.) have the potential for happening in any situation (consider the daily news of any city). We feel abuse will be found out sooner in a large facility with many people coming and going.

Since I have been visiting group homes, I have not seen any advantage to the residents over what they had at Great Oaks. They are not any more independent than they were before, they do not have the benefit of evening therapeutic programs with trained staff as GOC does, meals are not planned by a dietician as GOC, they have only two other residents like themselves to be with, and, if ambulatory, doors are locked to assure safety from traffic. GOC has a campus for them to roam.

In an effort to obtain Medicaid funds for community homes, our parents have been pressured and harassed by social workers to agree to placing their very retarded children out of the institution. Some are pleased. Many now have serious reservations about what they agreed to and today lead very worried lives.

Community living options for the most challenging population should be minimal. They lack the intellect to make a choice and their well-being in the community will always be dubious. The advantages of a large congregate facility can never be duplicated in a community.

A lady who calls me frequently is a mother of a mildly, retarded girl who lived in a group home until March of 1992 when she was sent to bed with a non-professional diagnosis of flu (although she reported that she was having trouble breathing) and died two days later of an aortic aneurysm. Her mother has said that her daughter had been required to care for a more retarded individual in the home on occasion. The mother had bought food for the home because aides told her they had none and she purchased locks for doors that had none.

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